DOCUMENT RESUME

ED 340 783 UD 026 381

TITLE	Death before Life: The Tragedy of Infant Mortality. Report. With Appendix and Testimonies at the National Hearing (4th, Chicago, Ilinois, April 25, 1988).
INSTITUTION	National Commission To Prevent Infant Mortality, Washington, DC.
PUB DATE	Aug 88
NOTE	404p.
PUB TYPE	Reports - Descriptive (141) -- Legal/Legislative/Regulatory Materials (090) -- Collected Works - Conference Proceedings (021)
EDRS PRICE	MF01/PC17 Plus Postage.
DESCRIPTORS	Birth Weight; Community Programs; Employed Parents; Federal Programs; Government Role; Health Insurance; *Health Needs; *Infant Mortality; *Medical Services; Mothers; Neonates; Policy Formation; *Pregnancy; Premature Infants; Prenatal Influences; *Primary Health Care; Private Financial Support; Program Development; Public Health
IDENTIFIERS	*Access to Health Care; *Maternal and Child Health Services; Medicaid; Partnerships; Public Private Relationship

ABSTRACT

A child born in Japan, Finland, Hong Kong, Ireland, Australia, Canada, Singapore, or any of 12 other industrialized nations has a better chance of surviving his or her first year than does a child born in the United States. This is because too many babies are born too small, too many are born too soon, and too many mothers never get decent care and guidance during their pregnancy. In 1985, 9.5 million women of childbearing age had no health insurance. Medicaid now assists less than 40 percent of America's poor and only half of America's poor children. The costs of prenatal care can be as little as $400 per mother; the lifetime costs of caring for a low birthweight infant can reach $400,000. The following recommendations are offered: (1) universal access to early maternal and pediatric care; all workplace health insurance coverage that includes maternity and infant care; government responsibility for those who lack insurance or are unable to pay; and (2) a sustained, broadbased effort to make the health and well-being of mothers and infants a national priority. Strategies for the public and private sectors, communities, and the government are offered. Illustrations accompany the text; a list of references is included. The appendix to this report contains: (1) results of a survey designed to elicit priority recommendations from recognized experts for reducing infant mortality in the U.S.; (2) a paper entitled "A History of Federal Initiatives To Reduce Infant Mortality"; and (3) a series of issue briefs on such topics as: low birthweight; postneonatal mortality; prenatal care; the financing of maternal and infant care; the Special Supplemental Food Program for Women, Infants, and Children (WIC); minority populations; and adolescent pregnancy. The second attachment to the document consists of testomonies on the role of government in reducing infant mortality. Two separate panels were heard. On panel 1, "Setting a National Policy Agenda for Mothers and Infants," the witnesses, all highly placed government officials, described why and how they made infant mortality and maternal and child health policy priorities and offered recommendations for a national policy. On panel 2, "Federal, State, and Local Leadership in Reducing Infant Mortality," administrators from all three governmental levels as well as other expert witnesses discussed issues of intergovernmental and interagency relationships regarding health and education programs and suggested possible solutions. (AA)

ED340783

Death Before Life:
THE TRAGEDY OF INFANT MORTALITY

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.
☐ Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Rae K. Grad
National Commission to Prevent Infant Mortality
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

The National Commission to Prevent Infant Mortality

August 1988

BEST COPY AVAILABLE

UD026381

Death Before Life:
THE TRAGEDY OF INFANT MORTALITY

The Report of
The National Commission to Prevent Infant Mortality

The Honorable Lawton Chiles
United States Senate
Chairman

Washington, D.C.
August 1988

The test of a nation is how it cares for children in the dawn of life.

Brooke Elizabeth English-Kelly

BEST COPY AVAILABLE

National Commission to Prevent Infant Mortality
Switzer Building • Room 2006
330 C Street, S.W. • Washington, D.C. 20201
202-472-1364

The Honorable Lawton Chiles
U.S. Senate
Chairman

The Honorable J. Roy Rowland
U.S. House of Representatives
Vice Chairman

MEMBERS

The Honorable Otis R. Bowen, M.D.
Secretary of Health and Human Services

The Honorable Charles A. Bowsher
U.S. Comptroller General

The Honorable David F. Durenberger
U.S. Senate

Herman A. Hein, M.D.
Professor of Pediatrics
University of Iowa

William H. Hollinshead III, M.D.
Medical Director & Chief
Rhode Island Division of
Family Health

Barbara D. Matula, Director
North Carolina Division of
Medical Assistance

Julius B. Richmond, M.D.
John D. MacArthur
Professor of Health Policy
Harvard University

The Honorable Richard W. Riley
Former Governor of South Carolina

Lynda Johnson Robb
Former First Lady of Virginia

The Honorable Thomas J. Tauke
U.S. House of Representatives

The Honorable James R. Thompson
Governor of Illinois

The Honorable Diane E. Watson
California State Senate

Margaret S. Wilson, Dean
Eastern Connecticut State University

Rae K. Grad, R.N., Ph.D.
Executive Director

August 4, 1988

Dear Friends:

It is a shocking fact that, in saving the lives of babies, America ranks 15th among the nations of the world.

It is shocking, alright. What makes it more so, is that those are not my words, and they are not from our time.

The words were Lyndon Johnson's and the time was 20 years ago. And what shocks us even more is that while we were 15th in 1968, today we are 19th.

A full generation of medical advancement has somehow come and gone without answering the riddle of why each year 40,000 American infants are dead before their first birthday.

For the past year, the National Commission to Prevent Infant Mortality has probed the experience of the nation's parents and professionals for answers. What we found is that too many infants are born too small, too many are born too soon, too many mothers never get decent care and guidance during their pregnancy.

Our fight against infant mortality has stalled because we have not reached the mothers and children at risk. We need to invest the kind of resources that provide preventive health care rather than waiting to provide costly "rescue" treatment later.

Our Commission report, therefore, calls for universal access to early, comprehensive maternity and infant care. And, second, it describes the need to make children's health and well-being a front-row national priority—not just to recognize the problem but to reach the people who need the help.

The Commission believes the nation has the means to help the children and the means and the need together justify a new beginning. We need to weld the resources of medicine, government, and community into a commitment and a capacity to care for mothers and infants.

No nation can long call itself great that does not put its children first. To that end, our Commission report is a hammer on the anvil of public commitment. And we want the echoes to spread throughout the country.

We want the dying to end, and we are convinced it can be ended. It is *not* inevitable that the grave and the cradle be one and the same for thousands of American infants.

Please join us in our fight to guarantee a healthy beginning for all.

Sincerely,

Lawton Chiles

Lawton Chiles, Chairman
National Commission to Prevent
Infant Mortality

CONTENTS

Introduction 7

Recommendations 12

- Every Mother and Every Baby Must be Able To Get the Health Care They Need: Universal Access 14
- This Nation Must Make The Health and Well-Being of Mothers and Babies A Top Priority 15

First Steps For Reducing Infant Mortality 16

- Financing Care: Pay Now or Pay Later 16
  - A PLAN OF ACTION 18
- Access to Care: Every Mother and Every Baby Must Be Able To Get The Health Care They Need 19
  - A PLAN OF ACTION 20
- This Nation Must Make the Health and Well-being of Mothers and Babies a Top Priority 22

Further Steps For Reducing Infant Mortality 26

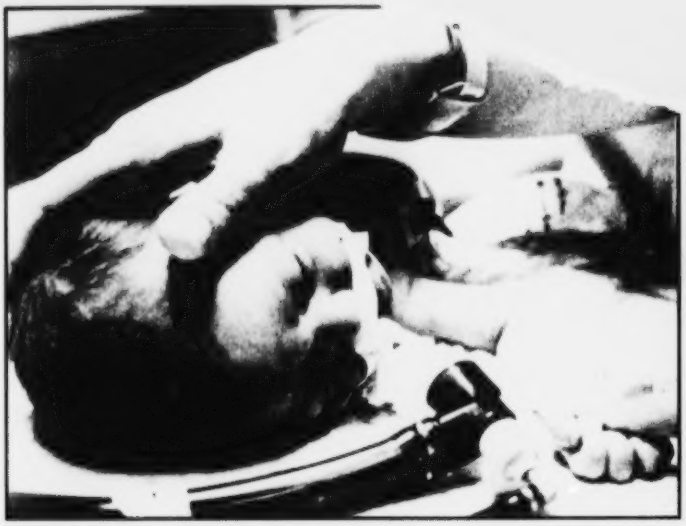
- Financing Care: Pay Now or Pay Later 27
- Access to Care: Every Mother and Every Baby Must be Able To Get The Health Care They Need 28
- Quality Services: Comprehensive, Coordinated Care 30
- Adding to Our Knowledge 31
- This Nation Must Make the Health and Well-Being of Mothers and Babies a Top Priority 33

Selected References 36

Acknowledgements 38

Information on the Commission 39

Members of the Commission 40



March of Dimes

We have a choice between placing babies in the arms of their mothers, or in the arms of technology. Just $400 in prenatal care could make the difference between a healthy baby and a baby who might need $400,000 of help throughout life to overcome difficulties and disabilities that could have been avoided.

BEST COPY AVAILABLE

INTRODUCTION

DEATH BEFORE LIFE: THE TRAGEDY OF INFANT MORTALITY

Joey came into this world three months too early and three and a half pounds too light. At one pound, thirteen ounces, he stood a fifty percent chance of survival. The odds that he would have other problems in life if he survived were even higher. Joey lived his first weeks on earth on a respirator. When he left the hospital, he spent his first months at home on a monitor. His parents couldn't find anyone willing or qualified to care for him, and so they couldn't leave him for a moment.

From the time Joey was two months old a social worker visited him and his family every week. A variety of other services—preventive care, vision teachers, mobility teachers—were available through county and state government social service programs. Where the services were not available, the family's private insurance helped fill the gaps.

Even so, it cost nearly $200,000 in medical bills before Joey could celebrate his third birthday this June. His only problem now is that he is blind. Joey has a deterioration of the retina as a result of the oxygen needed to keep him alive.

Joey is lucky. His parents were educated, middle-class, white-collar residents of a major metropolitan area. They sought out and used whatever resources they could find, and fortunately, their area provided comprehensive help. Unlike many families and their babies, they didn't fall through the cracks.

Other families aren't so fortunate.

Rhonda went for her first pregnancy test at the age of 16. The test alone cost $80. Before Rhonda left the clinic, she was told that she would have to pay $1,500 for the delivery of her child—and have to pay it in cash, before the seventh month, or they would drop her altogether. Only two doctors in her county delivered babies. Her friends told her that the other doctor also demanded cash up front for patients, like Rhonda, who lacked health insurance. With no money and no way to get to the nearest clinic, 26 miles away, she delayed a doctor visit until six months into her pregnancy.

Then, Rhonda heard about a medical center staffed by nurse midwives. She visited them and became briefly hopeful when she found she could afford the care. Then she had her first examination. The people at the clinic couldn't find the baby's heartbeat. The clinic referred her to another center, where they induced labor. The baby was stillborn at six and a half months.

Lizzie's husband worked for an orange grower. His employer's insurance covered only workers, not dependents. Lizzie applied for Medicaid but was rejected because she was married, and her husband owned a little bit of family land with his father. She and her husband sold everything they could to pay the doctor and hospital bills. It helped, but they couldn't get all the prenatal care she needed.

Marjorie Pyle, RNC, ACCE, Lifecircle, courtesy of ASPO/Lamaze

Whenever she could, Lizzie would drive to a neighboring state to see a private doctor. Late in her pregnancy, the doctor saw clear signs of an abnormal pregnancy. He sent her to a small hospital where a nurse midwife delivered a three-pound baby. The baby was transferred to another hospital with facilities to care for premature births. But for a month, Lizzie couldn't see her daughter because she couldn't get transportation. The baby is now five, cross-eyed, and slightly retarded—but alive.

Unlike Joey, or Lizzie's daughter, 40,000 infants in America each year do not live to celebrate their first birthday. Every hour of every day, five babies take their last breath. Each year, 11,000 babies weighing less than five and a half pounds—known as low birthweight babies—are born with long-term disabilities that result from their fragile condition. Unless we act today, in the next 13 years we will lose more American infants than we have lost soldiers in all the wars fought by the nation in this century.[1]

These facts would be sad enough were it not for the additional fact that at least half of the deaths are preventable, and many of the disabilities avoidable.

America prides itself for its moral leadership and concern for its citizens. That the tragedy of infant mortality is so prevalent in a wealthy nation such as ours is all the more distressing and depressing.

A child born in Japan, Finland, Hong Kong, Ireland, Australia, Canada, Singapore or any of twelve other industrialized nations has a better chance of surviving his or her first year than a child born in the United States of America.

For black infants, the story is even more heartbreaking. A black American infant is half as likely as a white child to live more than a year. A child born in Czechoslovakia or Bulgaria has a better chance of celebrating its first birthday than a black child born in America.

Within the United States, infant mortality is most severe in urban areas and the rural South. In 1985, four-fifths of our largest cities had infant mortality rates greater than the national rate. Of the 12 states with the highest rates of infant death, 10 are in the South.

But as Joey's mother could tell us, infant mortality transcends boundaries of geography, race, income and social class. No matter what circumstances a child is born into, no parent wants to leave a child behind in the hospital. And no mother or father wants to outlive his or her child. For all the figures that could be cited, when a parent loses a child the loss—and the sorrow—is total. The price we pay for this tragedy is great—in both human and economic terms.

---

[1] The total number of battlefield deaths of American forces in World War I, World War II, Korea, and Vietnam is 426,594; by the year 2000, some 520,000 infants can be expected to die if the recommendations of this report are ignored.

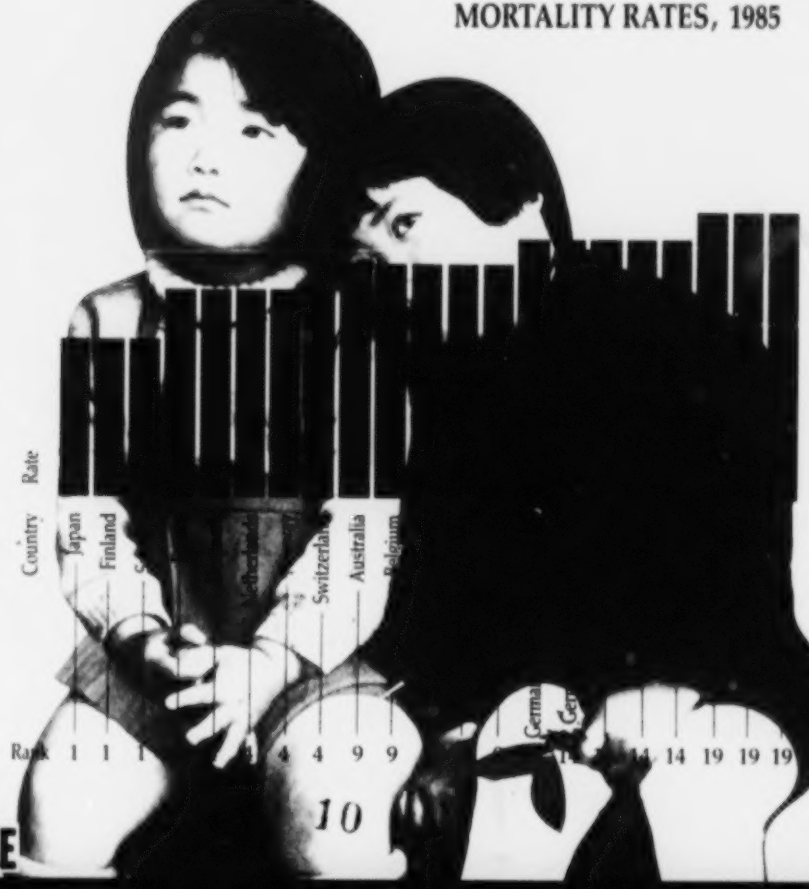
And, the costs of infant mortality are borne by all of American society.

Every low birthweight birth that could be averted would save the U.S. health care system between $14,000 and $30,000.

The lifetime costs of caring for a low birthweight infant can reach $400,000. The costs of prenatal care—care that might prevent the low birthweight condition in the first place—can be as little as $400.

Other countries do so much better than we do. Japan, for instance, surpasses all other industrialized nations in its infant mortality ranking. What separates Japan from the United States on the issue is not national wealth, or income, or technology, or training in the medical profession. Shortly after World War II, Japan ranked 17th in infant mortality rates. But in 1951, the Japanese enacted a "Children's Charter." When a mother registers a pregnancy, she receives a letter from the government congratulating her, and a handbook detailing what she must do to help ensure that she gives birth to a healthy baby. The letter and handbook may seem like gimmicks to a jaded American public, but they symbolize Japan's deep commitment to overcoming

INTERNATIONAL INFANT MORTALITY RATES, 1985



The infant mortality rate is the number of babies who are born alive but die before one year of age, per 1000 live births.

Source UNICEF

BEST COPY AVAILABLE

the tragedy of infant mortality—a commitment that has established Japan as the world leader in preventing infant mortality.

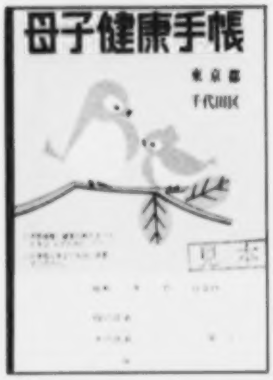
If we could achieve Japan's low rate of infant mortality, the 20,000 children whose lives would be saved each year would contribute in their lifetime up to $10 billion in productive earnings.

It is a commitment the United States must now make.

As Japan has proven, infant mortality is a problem with a solution. And as pediatrician Marsden Wagner of the World Health Organization has said, "Infant mortality is not a health problem. Infant mortality is a social problem with health consequences."

For generations, we have known how to improve the health of mothers and infants. Unlike other social problems, where cause and effect can blend together to obscure solutions, we know what we can do to halt the tragedy of infant mortality.

Medical genius alone will not solve the problem absent a far-reaching comprehensive health care delivery system. We have not significantly improved our rate of success in reducing the incidence of low birthweight babies because we have not significantly improved our capacity to find those in need and provide the up-front care. We spend vast amounts on a compassionate effort to save sick children, when we could spend far less to assure they are born healthy.


母子健康手帳
東京都
千代田区

BEST COPY AVAILABLE

In 1979, the United States established national health objectives for 1990. Thirteen of those top-priority goals concerned pregnancy and infant health. The Centers for Disease Control reports that we will probably meet only three of those thirteen goals. We will fall short on the overall infant mortality rate, on the rate for minorities, on the rate of low birthweight babies, and on the proportion of women who go without prenatal care in the first three months of pregnancy, among others.

We know that low birthweight puts babies at risk—for short and long-term complications, and for an early death. We know that prenatal care and early pediatric care are effective and cheap compared to the high technology care needed to sustain babies born at risk. We also know that we are reaching the limits of our ability to save babies at risk through technology.

Clearly, one key to reducing infant mortality is reducing the incidence of low birthweight babies. The rate of babies born too soon and too small has remained virtually unchanged since 1950. Sophisticated technologies and great expense can save babies born at risk. But we need to turn toward making sure that potential low birthweight babies are born at full weight.

The lack of access to health care, the inability to pay for health care, poor nutrition, unsanitary living conditions, and unhealthy habits such as smoking, drinking, and drug use all threaten unborn children. Unquestionably, poverty creates substantial risks—but infant mortality is not just a problem of poor people alone.

Our current health care system addresses infant mortality as a medical issue, rather than as a social problem with medical consequences. The cases of Joey, Rhonda and Lizzie offer instruction—and hope.

Joey and his parents had access to comprehensive services. With that support, Joey can look forward to leading a productive life.

Rhonda sought prenatal care in the first trimester of her second pregnancy. She was able to use a newly-opened satellite clinic office in her county. When she went into premature labor at 26 weeks, an obstetrician saw her, placed her on medication, and looked after her on a weekly basis. She went into labor at 38 weeks and, when the baby showed signs of distress, a caesarean section was performed. The baby had a mild case of pneumonia. Now, the child is fine.

From her cousin, Lizzie learned of a clinic where she could get prenatal assistance and advice on nutrition and other matters. Lizzie went to the center in her second trimester and carried a healthy baby to full term.

This report of the National Commission to Prevent Infant Mortality has been written with one principal goal in mind. It is our hope and belief that of all the nations in the world, babies born in the United States should have the best chance of living and fulfilling their promise.

RECOMMENDATIONS

Two major steps must be taken immediately if the United States is to activate our fight against infant mortality and if we are to assure our children and mothers the health and well-being that are their right.

FIRST, we must provide *universal access* to early maternity and pediatric care for all mothers and infants. The existing financial, administrative, logistical, geographical, educational, and social barriers to essential health services for pregnant women and infants must be eliminated. Employers must make available health insurance coverage that includes maternity and well-baby care. Government must assume responsibility for those who lack private insurance or are unable to pay.

SECOND, we must initiate immediately a sustained, broadbased effort to make the health and well-being of mothers and infants a national priority and give them the public attention and resources they deserve.

These broad courses of action are the major recommendations of this report. To implement these goals, federal, state, and local governments, business and industry, community organizations, and the public and private sector health care communities must assume the responsibility for specific actions. The recommendations offered in this report represent a strategy which can make a difference.

BEST COPY AVAILABLE

Communications Arts Company

The Alexandria Hospital

- *Every year 40,000 babies die in the United States. From now until the end of this century, 520,000 infants will die if the infant mortality rate continues unchecked. This is more than the total number of all battlefield deaths of American forces in World War I, World War II, Korea, and Vietnam.*

- *Medicaid, the federal-state public health financing program for the poor, now assists less than 40 percent of America's poor and only half of America's poor children. Between 1977 and 1983, the number of Americans in poverty grew by 10.5 million while the number of Medicaid recipients declined by 1.3 million.*

- *A black infant born in the United States is twice as likely to die before his or her first birthday than a white infant. A child born in Czechoslovakia or Bulgaria has a better chance of celebrating his or her first birthday than a black child born in the United States*

- *We can spend the money now or we can spend a lot more later. The costs of prenatal care—care that can prevent low birthweight—can be as little as $400 per mother. The lifetime costs of caring for a low birthweight infant can reach $400,000.*

BEST COPY AVAILABLE

EVERY MOTHER AND EVERY BABY MUST BE ABLE TO GET THE HEALTH CARE THEY NEED

Universal Access

Every baby should have the right to a healthy start in life. No pregnant woman or infant should go without preventive health services because avenues to care are blocked. Front-end maternity and early infant care are matters of life and death. They are far too important to allow anyone to fall through the cracks. Unless we make a commitment to providing universal access to maternity and infant care, the financial and human cost of infant mortality and morbidity will continue to climb. So will the cost to society of supporting the care and treatment of unhealthy children who, through no fault of their own, grow up with long-term disabilities or have difficulty becoming self-supporting adults.

The Commission holds that every pregnant woman and infant should be able to get the health care they need.

[redacted]

The health of a pregnant woman or infant should never depend solely on wealth. Health care should not be limited to those with the ability to pay. To the maximum extent possible, the private sector should make available health insurance coverage, with the government being the provider of last resort as resources become available.

[redacted]

In some rural areas, the closest health care facilities are hundreds of miles away. Often, mothers and infants needing help have no way of getting to or from a clinic.

Women seeking to enter medical or other public assistance programs are often forced to wait as long as 30 to 60 days while their case is considered. Often, pregnant mothers and their small children must wait hours to receive much needed services. Many mothers just give up out of frustration.

Where no services are available, public health departments or local hospitals should establish them. Where there are long forms to fill out, waiting lists, hard to reach clinics, poor transportation, lack of child care services, or other administrative barriers to care, agencies should knock down those barriers.

[redacted]

Pregnant women and infants must be guaranteed maternity and infant care as early as possible—women as soon as they know they are pregnant, infants as soon as they are born. Health services—prenatal, delivery, and pediatric—should be coordinated, comprehensive, sensitive to cultural differences, and consistent with accepted health care standards.

THIS NATION MUST MAKE THE HEALTH AND WELL-BEING OF MOTHERS AND BABIES A TOP PRIORITY

If the health and well-being of pregnant women, new mothers and infants is currently a national priority at all, it is far down the list. We are willing to spend an unlimited amount of money to keep low birthweight babies alive once they are born, but we are strangely reluctant to spend far less on the front-end preventive care that would make heroic, glamorous and expensive efforts to save young lives unnecessary. The consequence is that too many of our youngest children are dying. Our infant mortality rate is irrefutable evidence that although we care, we do not care enough. It is time we made a visible, tangible commitment to our children's health, to their quality of life, and to our nation's future—because it is cost-effective, and more importantly, because it is right.

The Commission recommends that a national campaign to bring infant mortality to the forefront of our country's awareness be launched and that there be established a permanent national council on children's health and well-being to focus efforts on preventing infant mortality and reducing infant morbidity.

U.S. Department of Health and Human Services

BEST COPY AVAILABLE

FIRST STEPS FOR REDUCING INFANT MORTALITY

FINANCING CARE: PAY NOW OR PAY LATER

Comprehensive maternity and infant care saves lives and money: those facts are well documented. We can spend the money now or we can spend a lot more later.

This nation's hospital bill for keeping low birthweight babies alive during their first year of life can be as high as $2 billion a year. The cost of providing front-end prenatal care for those women who do not currently receive it could be as little as $500 million.

One of the main reasons millions of pregnant women and infants do not get the health care they need is simply because they cannot afford it. Most Americans finance health care with insurance provided by or through their employer. But a job does not guarantee that a woman or her family will automatically have health insurance, or that the insurance they have will cover all their needs.

In 1985, 9.5 million women of childbearing age had no health insurance. More than 7 million of these women were married to workers or had jobs themselves. More than 20 percent of all children without health insurance lived with a parent who was insured through work.

Even those who have private insurance must often pay substantial out-of-pocket expenses, especially if their coverage specifies cost-sharing for maternity and well-baby care benefits, or if it restricts coverage for new policyholders who have personal or family histories of medical conditions such as diabetes. Some policies simply do not cover maternity care at all. **In 1987, five million women of childbearing age had private health insurance that did not cover maternity care.**

Public programs, primarily Medicaid, fill some of the gaps in coverage. But even Medicaid, the largest source of public funding of health care for pregnant women and infants, covers less than 40 percent of individuals in families with incomes below the federal poverty level—$9,690 per year for a family of three in 1988.

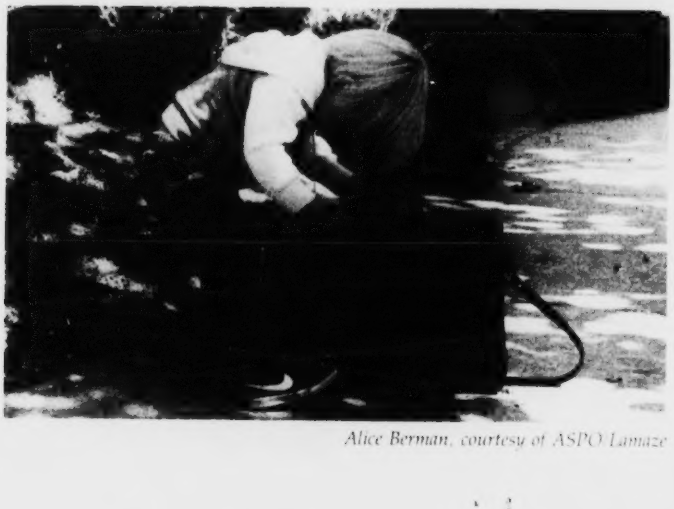
Medicaid coverage for the poor has eroded severely over the years. A family must be poorer today than a decade ago to qualify for Medicaid assistance. And there is no room for discretion: if a family's income is just a dollar above the cutoff for eligibility, coverage is unavailable.

Our patchwork system of health care financing leaves nearly 20 million women of childbearing age and children with no insurance whatsoever. Millions more have inadequate coverage.

Universal access to health care has been a goal, but not a reality, for some time. The Commission is encouraged and heartened by the recent expansions of Medicaid for pregnant women and young children. By July 1, 1990, all states will cover pregnant women and infants with family incomes at or below federal poverty level. In the private sector, some employers have begun to improve their maternity and well-baby coverage. The private sector has also worked with the public health community to improve access to health care at the state and local level.

But for all the progress we have made, it is not enough. The Commission's goal is straightforward: pregnant women and infants must be able to get health care. The private and public sectors must strengthen their commitment to ensure that women and infants can, in truth, obtain the services they need.

The Commission maintains that the first step toward guaranteeing pregnant women and infants the care they need is assuring financial access to maternity and infant care. The primary responsibility for achieving this goal rests with the private sector and employers who help provide the vast majority of health care in this country. But the government must assume more responsibility for those who lack private insurance or are unable to pay.



Alice Berman, courtesy of ASPO/Lamaze

BEST COPY AVAILABLE

[illegible]

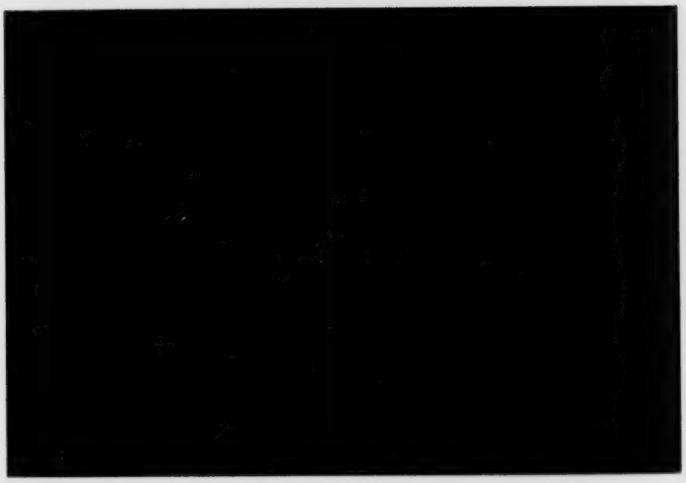
—Public Sector—

- The Medicaid program should be expanded to cover all pregnant women and infants who have family incomes at or below 200 percent of the federal poverty level.
- Assets tests for pregnant women applying for Medicaid should be eliminated. As of July 1988, 16 states still considered assets, such as a family automobile, in computing eligibility.
- Eligibility in Medicaid for pregnant women and infants should be continuous throughout the infant's first year of life.

—Private Sector—

- The private sector should make available prenatal and pediatric health care. All employment-based health insurance should include maternity and well-baby care coverage for employees, their spouses and dependents.
- Self-employed and unincorporated businesses should be allowed to deduct the full cost of health insurance as a business expense. Corporations already do this.
- To increase the availability and affordability of private group health insurance for small employers, insurance pooling mechanisms should be established.

U.S. Department of Health and Human Services



BEST COPY AVAILABLE

ACCESS TO CARE: EVERY MOTHER AND EVERY BABY MUST BE ABLE TO GET THE HEALTH CARE THEY NEED

Limited financial resources are not the only barriers between pregnant women and children and the care they need. There is also a formidable array of obstacles within the system that makes it difficult, if not impossible, to get care. Not the least among these is the fact that the United States lacks a national health policy defining the needs of mothers and infants and the services they require.

Even those eligible for Medicaid may be unable to get into the system. Sometimes they cannot locate documents to verify their eligibility. They may lack the ability, or even the self-confidence, needed to complete complex application forms. Sometimes the intimidating "official" surroundings deter them. They may be unaware of the program, or how or where to apply for it.

Needy people may live in rural or poor inner-city areas with few if any health care providers nearby. They may lack transportation. They may need child care to take advantage of services. They may be unable to get a timely appointment because of long waiting lists. They may be unable to cope with the hours, lines and procedures that are the hallmarks of bureaucracy.

And most importantly, they may be unaware of the critical need for early and continuous maternity and pediatric care.

In addition, providers of obstetric care, faced with escalating medical malpractice costs, are increasingly refusing to take high-risk patients, if they are taking any new patients at all. They may be unwilling to serve people because they are on Medicaid, or because they are poor and unable to pay. Often, they cannot speak the language of those who need their services.

Michael Weisbrot

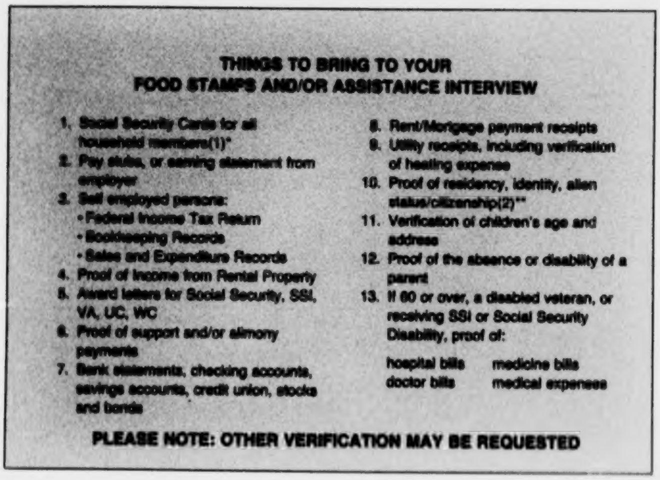
Some women and infants are in a more precarious position than others. Those who are poor, young, minority, substance abusers and those whose pregnancies are unintended are at greatest risk.

The Commission maintains that no pregnant woman or infant should go without preventive health care because the "system" currently prevents them from doing so. Maternity and early infant care are too important to allow anyone to fall through the cracks.

- Women must be made aware of the full array of available services as soon as they become pregnant. It would be best if pregnant women and infants could secure all necessary services at one location. At a minimum, there must be coordination of programs including Medicaid; Title V Maternal and Child Health Programs; the Special Supplemental Food Program for Women, Infants, and Children (WIC); Community and Migrant Health Centers; social and welfare services; mental health and mental retardation services; substance abuse, prevention and rehabilitation; special education; and family planning services.

- Congress should require that all Medicaid-eligible infants be automatically enrolled at birth in the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program. Currently, fewer than half of eligible children receive any EPSDT services. States should also be required to offer follow-up services for any problems identified in the screenings.

[redacted]

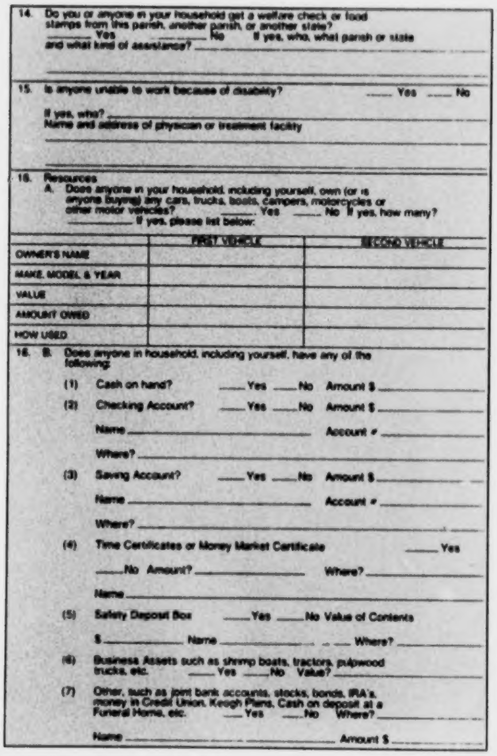


THINGS TO BRING TO YOUR
FOOD STAMPS AND/OR ASSISTANCE INTERVIEW

1. Social Security Cards for all household members(1)*
2. Pay stubs, or earning statement from employer
3. Self employed persons:
   - Federal Income Tax Return
   - Bookkeeping Records
   - Sales and Expenditure Records
4. Proof of Income from Rental Property
5. Award letters for Social Security, SSI, VA, UC, WC
6. Proof of support and/or alimony payments
7. Bank statements, checking accounts, savings accounts, credit union, stocks and bonds
8. Rent/Mortgage payment receipts
9. Utility receipts, including verification of heating expense
10. Proof of residency, identity, alien status/citizenship(2)**
11. Verification of children's age and address
12. Proof of the absence or disability of a parent
13. If 60 or over, a disabled veteran, or receiving SSI or Social Security Disability, proof of:

hospital bills	medicine bills
doctor bills	medical expenses

PLEASE NOTE: OTHER VERIFICATION MAY BE REQUESTED



14. Do you or anyone in your household get a welfare check or food stamps from this parish, another parish, or another state?
______ Yes ______ No If yes, who, what parish or state and what kind of assistance? ______

15. Is anyone unable to work because of disability? ____ Yes ____ No
If yes, who? ______
Name and address of physician or treatment facility
______

16. Resources
A. Does anyone in your household, including yourself, own (or is anyone buying) any cars, trucks, boats, campers, motorcycles or other motor vehicles? ____ Yes ____ No If yes, how many? ______ If yes, please list below:

	FIRST VEHICLE	SECOND VEHICLE
OWNER'S NAME		
MAKE, MODEL & YEAR		
VALUE		
AMOUNT OWED		
HOW USED		

16. B. Does anyone in household, including yourself, have any of the following:
(1) Cash on hand? ____ Yes ____ No Amount $ ______
(2) Checking Account? ____ Yes ____ No Amount $ ______
Name ______ Account # ______
Where? ______
(3) Saving Account? ____ Yes ____ No Amount $ ______
Name ______ Account # ______
Where? ______
(4) Time Certificates or Money Market Certificate ____ Yes
____ No Amount? ______ Where? ______
Name ______
(5) Safety Deposit Box ____ Yes ____ No Value of Contents
$ ______ Name ______ Where? ______
(6) Business Assets such as shrimp boats, tractors, pulpwood trucks, etc. ____ Yes ____ No Value? ______
(7) Other, such as joint bank accounts, stocks, bonds, IRA's, money in Credit Union, Keogh Plans, Cash on deposit at a Funeral Home, etc. ____ Yes ____ No Where? ______
Name ______ Amount $ ______

Even if eligible for Medicaid, the application process can be time consuming and cumbersome delaying access to timely prenatal care. Determining eligibility can take a month and application forms range from 3 to 52 pages.

- The Medicaid application forms must be simplified and states should adopt a streamlined eligibility process, such as "presumptive eligibility" under which all pregnant women applying for Medicaid would be immediately eligible for services for up to 45 days or until the formal application is denied or accepted, whichever is sooner. As of July 1988, only 19 states had adopted the presumptive eligibility process.

- The number of providers willing to serve high-risk pregnant women and infants must be increased and the malpractice crisis must be addressed. The Commission encourages the development of demonstration projects to test innovative ways to increase the participation of obstetricians, family physicians, pediatricians and certified nurse midwives in Medicaid and underserved communities.

- In order to encourage more maternity and pediatric providers to participate in the Medicaid program, states should examine ways to adjust their Medicaid reimbursement rates and simplify the administrative requirements.

- A "home visitors program" for pregnant women and new mothers, particularly those in high-risk populations, should be established. The program could educate and work with pregnant women throughout their pregnancies to promote healthy outcomes. Community organizations and volunteers could be trained to encourage healthy behavior and to refer pregnant women and infants to appropriate services.

BEST COPY AVAILABLE

THIS NATION MUST MAKE THE HEALTH AND WELL-BEING OF MOTHERS AND BABIES A TOP PRIORITY

Sadly, knowledge of the tragedy of infant mortality is confined largely to those who experience it—either its human or financial costs. Before our nation can devote the resources needed to succeed in the fight against infant mortality, we must first make the public aware of the extent—and the seriousness—of the problem.

In America today, mass media—television, newspapers, radio—are the most important shapers of public consciousness and opinion. In recent years, they have contributed to raising public awareness about a number of health problems, including smoking, AIDS, and substance abuse. But hard experience tells us that a limited, one-shot series of 15-second public service advertisements will not do the job—especially when many of the people most at risk will not see them.

Our success in making the health of pregnant women and children a national priority depends, in large measure, on the amount of continuing visibility these efforts have in the eyes of the nation. Unfortunately, the existing federal structure does not provide significant exposure for maternal and child health issues. It fails to provide the kind of unified leadership provided by the Children's Bureau prior to its dissolution in 1969. It does not encourage full coordination of federally sponsored services to pregnant women and infants to issue a clarion call for action. But we have done it before.

40 YEARS OF SERVICE FOR CHILDREN
Happy Birthday
Children's Bureau

U.S. Department of Health and Human Services

In the 1950s, this nation rallied its forces to fight polio. The public was poised and ready to begin using the vaccine. Newspapers and radios were calling for all children to be vaccinated. However, the vaccine was not immediately accessible to all and not all understood the importance of being vaccinated.

Fortunately, community volunteers and health care providers committed their resources and made sure that all in need were vaccinated. Public health clinics extended their hours to meet the needs of working

Maternal and Child
Health Handbook

parents. Schools required proof of vaccination and for those unvaccinated provided information on how to get the inoculation. Within a surprisingly short period of time, every child under the age of 20 and all pregnant women in this country were free of the fear of polio.

The Commission believes that a single entity, such as a permanent council on children's health and well-being, could serve as a national focal point for developing and executing a public awareness campaign on infant mortality. The council might begin by developing and distributing to every pregnant woman a maternal and child health handbook, based on the Japanese model, to encourage early prenatal care and serve as an infant's health record. The council must work closely with the public and private sector, academia, the media and state and local leaders.

The council's permanence would ensure that its actions become an integral part of this nation's planning and budgeting for children.

A national council should:

- Design and implement a national awareness campaign to promote maternal and child health. An expert panel of television, radio, print journalism and advertising executives, along with medical and public health experts and private sector representatives could be established to advise on such a campaign.

- Provide coordination with the U.S. Departments of Health and Human Services, Agriculture, Education, Housing and Urban Development, and other federal agencies to promote the health and well-being of mothers and children.

- Serve as a liaison between public and private sector initiatives and collaborative efforts for mothers and children and as a national focal point for information and activities on maternal and child health.

BEST COPY AVAILABLE

Over the course of the 20th century, the United States has made great strides in improving maternal and child health. Yet, as the 1900s draw to a close and we embark on a new century, the efforts have fallen short of ensuring the health of pregnant women and young children and of reducing infant mortality to the lowest level possible. The patchwork system of programs and services continues to leave millions of mothers and infants without access to quality care and at risk for numerous health problems, many of which are preventable.

World War I **The Great Depression**

1900 **1910** **1920** **1930**

1909—First White House Conference on Dependent Children.

1

1900s—Milk stations established to provide a clean milk supply for children.

1908—First Division of Child Hygiene established (New York City).

2

1909—Organized prenatal care services began to develop.

1909—American Association for the Study and Prevention of Infant Mortality founded.

1919—White House Conference on Child Welfare Standards.

1912—Federal Children's Bureau established.

Julia C. Lathrop
First Chief of the Children's Bureau

1914—Baby Saving Campaigns held in communities nationwide, sponsored by the Children's Bureau.

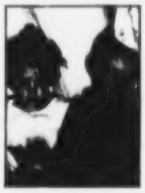
1915—National Birth Registry established.

1921—Maternity and Infancy Act (Sheppard-Towner Act) passed into law. First federal grants-in-aid program to promote maternal and child health.

1928—First National Child Health Day, designated May 1.

1929—Funding for Sheppard-Towner Act ended.

1930—White House Conference on Child Health and Protection.



1935—Social Security Act signed into law with Title V modeled after the Sheppard-Towner Act to provide grants to states to improve maternal and child health and welfare.

Photos 1 and 2—Boston Visiting Nurse Association. Courtesy of the Center for the Study of the History of Nursing, the University of Pennsylvania.

All other photos—U.S. Department of Health and Human Services

BEST COPY AVAILABLE

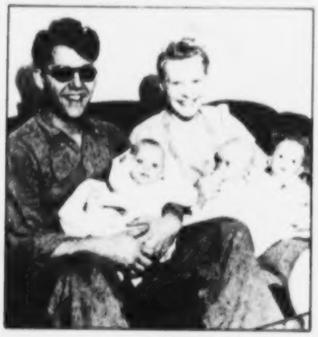
World War II **Baby Boom** **The Great Society**

1940 **1950** **1960** **1970** **1980** **1990**

1940—White House Conference on Children in a Democracy.

1940s—Rate of births occuring in hospitals increased.

1940s—Antibiotics introduced.



1943—Emergency Maternity and Infant Care Act passed into law to provide health care to wives and children of servicemen.

1950—Midcentury White House Conference on Children and Youth.

1950s—Prepared infant formula introduced.

1953—U.S. Department of Health, Education, and Welfare formed.

1960—Golden Anniversary White House Conference on Children and Youth.

1963—Title V amended to create Maternity and Infant Care programs.

1965—Medicaid and Medicare programs established.

1965—Federal Comprehensive Neighborhood Health Centers program established; later became known as the Community Health Centers program.

1965—Federal Migrant Health Centers program established.

1966—Special Supplemental Food Program for Women, Infants, and Children (WIC) authorized; implemented in 1972.

1967—Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children enacted.

1969—Children's Bureau dismantled.

1970—White House Conference on Children.

1970s—Growth of neonatal intensive care units.

1970s—Improved Pregnancy Outcome programs promoted the regionalization of maternal and child health services.

1970—National Health Service Corps established to place health professionals and resources in underserved areas.

1979—U.S. Surgeon General's report, *Healthy People*, set 1990 Health Goals for the Nation, including goals and objectives for maternal and infant health.

1981—Title V programs consolidated into the Maternal and Child Health Services Block Grant.

1981—*Better Health for Our Children: A National Strategy*, report of the Select Panel for the Promotion of Child Health to the U.S. Congress and the Secretary of Health and Human Services.

1983—The Select Committee on Children, Youth, and Families formed in the U.S. House of Representatives.

1985—*Preventing Low Birthweight*, report of the Institute of Medicine.

BEST COPY AVAILABLE

FURTHER STEPS FOR REDUCING INFANT MORTALITY

Marjorie Pyle, RNC, ACCE, Lifecircle, courtesy of ASPO/Lamaze

The major recommendations of this report will have little impact if they are not accompanied by further steps to reach pregnant women and infants in communities across the nation. Responsibilities must be assumed by—and resources must come from—state and local governments, communities, and the private sector, over and above what the federal government must do.

Infant mortality is a national tragedy. But our ability to reduce it depends on our success in adopting approaches appropriate to diverse and distinct communities. For too long, we have turned to doctors—and doctors alone—for answers. The mandate of this Commission is to identify solutions to the infant mortality problem, and to direct any and every available resource and institution toward solving this problem. It is time to ask others to live up to their community responsibilities. The recommendations that follow constitute a more detailed plan of action for reducing the tragedy of infant mortality.

BEST COPY AVAILABLE

Financing Care: Pay Now or Pay Later

Government:

- Current exemptions in the federal Pregnancy Discrimination Act of 1978—which requires most employers who offer health insurance to their employees to include maternity coverage—should be eliminated so that maternity coverage is available to all women who are insured under private plans. Employers with 15 or fewer employees and dependents of employees who are not spouses should be covered by the Act.

- States should require that well-baby care be included in all group insurance plans.

- States should require that group health insurance policies eliminate waiting periods and pre-existing condition clauses for pregnancy related care.

- States should require that health insurance risk pools for people who are unable to purchase private insurance because of pre-existing medical conditions (medically uninsurable people) include maternity and well-baby care.

Community and Private Sector:

- Business associations should develop educational programs for employers about the long-term cost-effectiveness of insurance benefits for prenatal and preventive well-baby care.

- Business leaders should educate their colleagues and employees about the importance and cost-effectiveness of preventive prenatal and well-baby care.

THE

BURLINGTON LOOK

Prenatal care: Getting baby off to a healthy start

Burlington Industries has implemented a strong maternal and child health educational effort directed toward pregnant employees and their spouses.

BEST COPY AVAILABLE

Access To Care: Every Mother and Every Baby Must Be Able To Get The Health Care They Need

Government:

■ The Secretary of Health and Human Services should require that all women and infants, particularly those at high risk, be guaranteed entry into a system of regionalized, risk-appropriate, obstetrical and pediatric care. The Secretary should require that standards for federally supported maternity and infant care be developed.

■ The Secretary of Health and Human Services should expand the department's work with the states and with health professionals to address their malpractice concerns and increase the number of providers who serve high-risk pregnant women and infants.

To accomplish this, the Secretary could:

- Test innovative ways to increase the participation of obstetricians, family physicians, pediatricians and certified nurse midwives in Medicaid. Demonstration projects could include initiatives to deal with medical malpractice, related liability issues and low reimbursement levels.[2]
- Encourage fair and effective peer review among providers of obstetrical care.[2]
- Encourage risk-management and quality assurance in health care facilities and for health care professionals.[2]
- Develop educational programs for health professionals and the general public on malpractice issues.[2]
- Develop more effective strategies to bring minorities into the health care professions.

■ The Secretary of Agriculture should increase the department's efforts to bridge the gaps that inhibit women at risk from using existing services, particularly WIC.

■ The Secretary of Health and Human Services should set up a national network of "hotlines" to provide information on access to maternity and infant care, particularly preventive services and general health education.

■ States should provide supplemental funding for WIC so that all those eligible may be served.

■ States should establish "State Maternal and Child Health Councils" to monitor activities and progress in preventing infant mortality and morbidity. The Councils should promote the coordination and increase the accessibility of services to mothers and infants, especially where there are high infant mortality rates. The goal should be to make services available in every community.

■ Governors should require their state health departments and Medicaid offices to determine why providers are reluctant to participate in Medicaid and other public programs serving pregnant women and infants, and develop

Michael Weisbrot

---

[2] These are discussed in detail in the *Report of the Task Force on Medical Liability and Malpractice*, U.S. Department of Health and Human Services, August 1987.

strategies for bringing them into the programs.

- States should develop a plan with the state boards of education to work with local school officials to implement family life education courses through all grades in all schools.

- Governors should identify specific geographic areas with high rates of infant mortality, declare them "Infant Mortality Disaster Areas," and mobilize and coordinate resources and efforts to attack the problem.

- States should encourage the establishment and expansion of certified nurse midwifery training programs in the state university system.

- State and local health departments can and should use a variety of administrative options to serve more women and infants and to identify areas of persistent need:
  - Private health care providers should be more involved in meeting the needs of high-risk populations.
  - When a pregnancy is confirmed, there should be an immediate referral to a health care provider.
  - Schedules should be organized so that women can be seen within two weeks of their request for an appointment, and all missed appointments should be followed up routinely.
  - Indigenous community outreach workers should be trained to support efforts to reach pregnant women and infants.
  - Telephone "hotlines," linked to the national hotline, should be set up to answer questions concerning the availability of care, who qualifies for care, where and how to apply, and to communicate the importance of preventive care.
  - Mobile health units, satellite clinics, health clinics at schools, and other mechanisms should be organized to provide quality care to people in urban and rural areas who are not currently being served.

Marjorie Pyle, RNC, ACCE, Lifecircle, courtesy of ASPO/Lamaze

Communities and Private Sector:

- Businesses, community and religious groups should work together to improve access to health care for pregnant women and infants by, for example, volunteering transportation and child care assistance.

- Commercially available pregnancy testing kits should include information on the need for early and adequate prenatal health care.

- Groceries, pharmacies and retail stores should make maternal and child health education materials widely available and include information about local services that are available to pregnant women and children.

- Local public health officials, in conjunction with health care providers (including maternal and child health clinics and community and migrant health centers) and community leaders, should develop strategies to identify pregnant women and infants eligible for Medicaid, and assist them in applying for the program.

Quality Services: Comprehensive, Coordinated Care

Government:

- The Secretary of Health and Human Services, through the Health Care Financing Administration, should require that all pregnant women in the Medicaid program be screened to determine if they are in a high-risk group. Where necessary, they should be referred to appropriate available services.

- The Secretary of Health and Human Services should redouble the department's efforts to eliminate smoking, drinking and substance abuse among pregnant women, and to reduce substance abuse among women of childbearing age. A special component of this effort should focus on drug abuse and the spread of the AIDS virus to infants during pregnancy.

- The Secretary of Health and Human Services, in conjunction with state agencies, local drug-abuse officials, and representatives of drug treatment programs, should develop and implement a plan for meeting the increasing demand for drug treatment services, particularly for women of childbearing age who need those services.

- State and local health departments and other agencies, in cooperation with hospitals, should guarantee that every newborn child is discharged to an identified health care provider who will assume responsibility for coordinating health services for the infant (i.e., a medical home).

- Governors should require their states to develop and implement statewide plans for preventive maternity and infant care that include coordinated, comprehensive services. The plans should respect cultural differences, and provide medical, nutrition, education, and social support services appropriate to the risks of the populations involved.

- State and local health departments should provide continuing education for their staffs on the unique cultural needs of the people they serve. They should have bilingual staffs or trained translators at sites serving people for whom English may not be a first language.

- State departments of health and education should increase their efforts to develop education programs for women, teenagers, and their partners about the consequences of unintended pregnancies, and promote alternatives such as delaying sexual activity or using contraceptives.

Community and Private Sector:

■ Community and religious groups should develop programs targeted to people at risk, including programs in nutrition, parenting, smoking cessation, elimination of alcohol and substance abuse, family life education, self-esteem development and life-options education.

■ Business and community groups should work with local school districts to develop job-training programs for women and girls at risk for unintended pregnancies and encourage them to finish their education.

Adding To Our Knowledge

Government:

■ Congress should require the Secretary of Health and Human Services to develop and oversee a comprehensive, coordinated research agenda for all maternal and child health issues.

Michael Weisbrot

■ Congress should require the states to report systematically on the numbers of women and infants (and their race and ethnicity) being served by federal programs highlighted in this report, as well as on the specific services they receive.

■ Federal agencies such as the National Institute of Child Health and Human Development, the Centers for Disease Control, and the Bureau of Maternal and Child Health and Resources Development, should expand their basic, epidemiological and clinical research on:

- motivating women at high risk to seek and continue preventive health care;
- preventing premature labor and intra-uterine growth problems;
- preventing and treating babies born with birth defects, fetal alcohol syndrome, cocaine addiction and AIDS;

BEST COPY AVAILABLE

- the interplay between demographic, social, cultural, biological and environmental factors that affect the incidence of low birthweight and infant mortality;

- the causes of Sudden Infant Death Syndrome;

- strategies to improve access to and delivery of maternity and infant health care services, particularly in rural and inner-city urban areas.

■ The National Center for Health Statistics, together with the Bureau of Maternal and Child Health and Resources Development, the Bureau of Health Care Delivery and Assistance, the Health Care Financing Administration, and the Department of Agriculture, should develop the data needed to establish relationships between child health indicators, low birthweight, insurance status, and participation in public programs such as Medicaid and WIC. This information is critical in monitoring and evaluating the impact of public policies and programs.

■ State health departments should adopt the 1989 revised standard birth and death certificates, and fully report all items, including data on ethnic origin, use of prenatal care, and all other factors associated with pregnancy and delivery, including medical, social and demographic factors.

■ State and local health departments should establish expert review panels to investigate each infant death and pregnancy that results in problems, forwarding the information to state vital statistics and epidemiological offices.

■ State and local health departments should work with hospitals to strengthen discharge planning and follow-up programs for low birthweight babies.

■ State health departments should adopt the National Center for Health Statistics' recommended definitions and reporting standards for live births and fetal deaths which are based on the World Health Organization's recommended definitions.

Community and Private Sector:

■ Communities, in cooperation with state and local health departments and private and public health care providers, should use techniques such as surveys and structured interviews to systematically identify the barriers to infant and maternity care unique to each community, and then implement solutions.

■ Physicians, hospitals and coroners should more accurately identify causes of death on the death certificates of infants. Classifying the majority of infant deaths as "other," or as a result of "Sudden Infant Death Syndrome," masks important information needed to reduce infant mortality.

This Nation Must Make the Health and Well-Being of Mothers and Babies a Top Priority

Government, Community and Private Sector:

- The Secretary of Health and Human Services should develop, promote, and distribute to all pregnant women a maternal and child health handbook, based on the Japanese model, designed to encourage early prenatal care and serve as an infant's health record. In conjunction with that effort, a national network of hotlines for providing information on maternal and child health should be established.

- The White House Conference on Children, in the tradition established by Theodore Roosevelt in 1909 and maintained by presidents in every decade through 1970, should be revitalized.

- National, state, and local elected officials should report annually on the progress being made to reduce infant mortality and improve children's health. Such reports should be accompanied by proposals to address continuing problems.

- Governors and state legislatures should convene annual "State Conferences on Children" to report on progress and refine strategies for promoting maternal and child health.

- State health departments should implement statewide media campaigns, in concert with the national campaign, to promote the health and well-being of

Vote
Children
'88

U.S. Department of Health and Human Services

BEST COPY AVAILABLE

mothers and infants. These should be based on market research to determine how to best assure that the message concerning the need for and availability of services actually reaches women and their families.

- National, state, and local government associations should develop continuing initiatives to promote maternal and child health. They should also encourage state policies to prevent infant mortality and morbidity.

- Organizations of health professionals should encourage their members to participate fully in promoting and using the maternal and child health handbook.

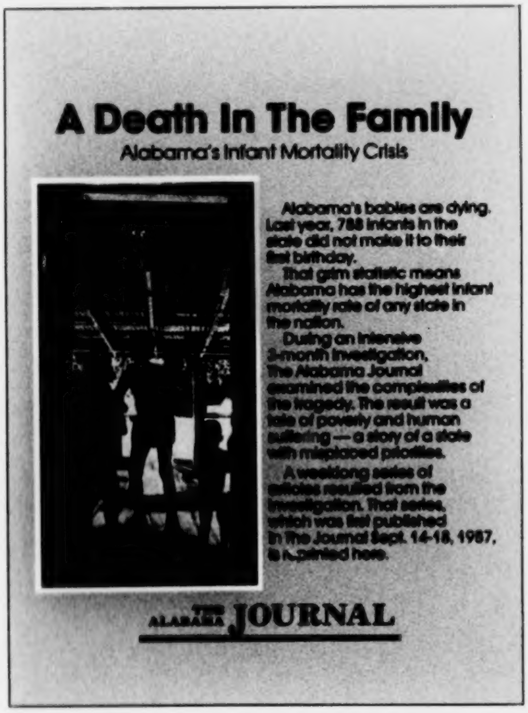
- National organizations of artists, writers, and performers should speak out on behalf of children's health, with a special focus on high-risk populations.

- National media organizations, state broadcast organizations, and their local counterparts should encourage multi-media, multi-cultural campaigns to promote the health and well-being of pregnant women and infants.

- National business and labor organizations and their local chapters and affiliates should develop policy statements and initiatives to benefit mothers and infants.

- Neighborhood churches and synagogues should develop and support community public awareness programs to emphasize the importance of preventive care for pregnant women and infants.

- International links, such as a "Sister Cities" project, and an international summit of health ministers from around the world to share strategies for promoting maternal and child health initiatives from other nations should be developed.



A Death In The Family

Alabama's Infant Mortality Crisis

Alabama's babies are dying. Last year, 788 infants in the state did not make it to their first birthday.

That grim statistic means Alabama has the highest infant mortality rate of any state in the nation.

During an intensive 3-month investigation, The Alabama Journal examined the complexities of the tragedy. The result was a tale of poverty and human suffering — a story of a state with misplaced priorities.

A weeklong series of articles resulted from the investigation. That series, which was first published in The Journal Sept. 14-18, 1987, is reprinted here.

THE ALABAMA JOURNAL

Mickey Welsh Alabama Journal

The Alabama Journal of Montgomery recently ran a five-part, twenty-article series on infant mortality for which they were awarded the Pulitzer Prize for General News Reporting.

Michael Weisbrot

BEST COPY AVAILABLE

SELECTED REFERENCES

U.S. Department of Labor, Children's Bureau, *Baby Saving Campaigns, a Preliminary Report on What American Cities are Doing to Prevent Infant Mortality*, Infant Mortality Series No. 1, Bureau Pub. No. 3, U.S. Government Printing Office, Washington, D.C., 1914.

U.S. Department of Labor, Children's Bureau, *Birth Registration: An Aid in Protecting the Lives and Rights of Children*, U.S. Government Printing Office, Washington, D.C., 1914.

U.S. Department of Labor, Children's Bureau, *Maternity Benefit Systems in Certain Foreign Countries*, Legal Series No. 3, U.S. Government Printing Office, Washington, D.C., 1919.

U.S. Department of Labor, Children's Bureau, *Prenatal Care*, U.S. Government Printing Office, Washington, D.C., 1924.

U.S. Department of Labor, Children's Bureau, *Standards of Prenatal Care: An Outline for the Use of Physicians*, Bureau Pub. No. 153, U.S. Government Printing Office, Washington, D.C., 1925.

U.S. Department of Labor, Children's Bureau, *Infant and Maternal Mortality among Negroes*, Bureau Pub. No. 243, U.S. Government Printing Office, Washington, D.C., 1937.

U.S. Department of Labor, Children's Bureau, *Services for Unmarried Mothers and Their Children*, U.S. Government Printing Office, Washington, D.C., 1945.

Bradbury, D.E., *Five Decades of Action for Children: A History of the Children's Bureau*, U.S. Department of Health, Education and Welfare, Children's Bureau, U.S. Government Printing Office, Washington, D.C., 1962.

U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, *The Story of the White House Conferences on Children and Youth*, U.S. Government Printing Office, Washington, D.C., 1967.

Falkner, F. (ed.), *Key Issues: Infant Mortality, Report of a Conference*, Department of Health, Education, and Welfare, National Institute of Child Health and Human Development, U.S. Government Printing Office, Washington, D.C., 1969.

National Academy of Sciences, Food and Nutrition Board, Committee on Maternal Nutrition, *Maternal Nutrition and the Course of Pregnancy: Summary Report*, Washington, D.C., 1970.

World Health Organization, *The Prevention of Perinatal Mortality and Morbidity*, Technical Report Series No. 457, Geneva, Switzerland, 1970.

U.S. Department of Health, Education, and Welfare, *Report to the President: White House Conference on Children (1970)*, U.S. Government Printing Office, Washington, D.C., 1971.

U.S. Department of Health, Education, and Welfare, *Promoting the Health of Mothers and Children*, U.S. Government Printing Office, Washington, D.C., 1971.

U.S. Department of Health, Education, and Welfare, *Promoting the Health of Mothers and Children*, Washington, D.C., 1973.

U.S. Department of Health, Education, and Welfare, *Projects for Intensive Care: New Hope for the Newborn*, DHEW Pub. No. 745010, Washington, D.C., 1974.

U.S. Department of Health, Education and Welfare, *The Maternity and Infant Care Projects: Reducing Risks for Mothers and Babies*, DHEW Pub. No. 75-5012, Washington, D.C., 1975.

March of Dimes Birth Defects Foundation, *Toward Improving the Outcome of Pregnancy: Recommendations for the Regional Development of Maternal and Perinatal Health Services*, White Plains, New York, 1976.

The Robert Wood Johnson Foundation, *Special Report: Regionalized Perinatal Services*, Princeton, New Jersey, 1978.

Davis, K. and C. Schoen, *Health and the War on Poverty: A Ten Year Appraisal*, The Brookings Institution, Washington, D.C., 1978.

U.S. Department of Health, Education, and Welfare, Office of the Assistant Secretary for Health and Surgeon General, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*, DHEW (PHS) Pub. No. 79-55071, U.S. Government Printing Office, Washington, D.C., 1979.

U.S. Department of Health and Human Services, Public Health Service, *Promoting Health/Preventing Disease: Objectives for the Nation*, DHHS Pub. No. (OM) 81-0007, U.S. Government Printing Office, Washington, D.C., 1980.

U.S. General Accounting Office, *Better Management and More Resources Needed to Strengthen Federal Efforts to Improve Pregnancy Outcome*, HRD-80-24, Washington, D.C., January 21, 1980.

U.S. Department of Health and Human Services, *Better Health for Our Children: A National Strategy*, the Report of the Select Panel for the Promotion of Child Health, DHHS Pub. No. (PHS) 79-55071, U.S. Government Printing Office, Washington, D.C., 1981.

U.S. Department of Health and Human Services, Public Health Servce, *Surgeon General's Workshop on Maternal and Infant Health*, Washington, D.C., 1981.

U.S. Department of Health and Human Services, Public Health Service, *Report of the Secretary's Task Force on Black and Minority Health, Vol. VI: Infant Mortality and Low Birthweight*, Washington, D.C., 1983.

The Ford Foundation, *Child Survival: Fair Start*, Pub. No. 429, New York, 1983.

President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Securing Access to Health Care. A Report on the Ethical Implications of Differences in the Availability of Health Services*, Washington, D.C., 1983.

Southern Governors' Association, Southern Regional Task Force on Infant Mortality, *Final Report: For the Children of Tomorrow*, Washington, D.C., 1985.

Institute of Medicine, *Preventing Low Birthweight*, National Academy Press, Washington, D.C., 1985.

Childrens' Defense Fund, *The Childrens' Defense Fund's Adolescent Pregnancy Prevention/Prenatal Care Campaign*, Washington, D.C., 1985.

National Center for Clinical Infant Programs, *Warning Signals: Basic Criteria for Tracking At Risk Infants and Toddlers*, Washington, D.C., 1986.

U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Improving MCH/WIC Coordination: A Final Report and Guide to Good Practices*, Washington, D.C., August 1986.

The Robert Wood Johnson Foundation, *Rural Infant Care Program*, Special Report No. 2, Princeton, New Jersey, 1986.

U.S. Department of Health and Human Services, Public Health Service, *The 1990 Health Objectives for the Nation: A Midcourse Review*, November 1986.

Committee for Economic Development, *Children in Need: Investment Strategies for the Educationally Disadvantaged*, New York, 1987.

The Alan Guttmacher Institute, *Blessed Events and the Bottom Line: Financing Maternity Care in the United States*, New York, 1987.

Miller, A.C., *Maternal Health and Infant Survival*, National Center for Clinical Infant Programs, Washington, D.C., 1987.

American Nurses Association, *Access to Prenatal Care: Key to Preventing Low Birthweight*, Kansas City, Missouri, 1987.

Food Research and Action Center, *Poor Infants, Poor Chances: A Longitudinal Study of Progress Toward Reducing Low Birth Weight and Infant Mortality in the United States and its Largest Cities, 1979-1984*, Washington, D.C., 1987.

The Robert Wood Johnson Foundation, *Special Report: Access to Health Care in the United States: Results of a 1986 Survey*, Special Report No. 2, Princeton, New Jersey, 1987.

U.S. General Accounting Office, *Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care*, HRD-87137, Washington, D.C., September 1987.

The Alan Guttmacher Institute, *The Financing of Maternity Care in the United States*, New York, December 1987.

U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future*, OTA-H-345, U.S. Government Printing Office, Washington, D.C., February 1988.

ACKNOWLEDGEMENTS

The work of the National Commission to Prevent Infant Mortality could not have been completed without the contributions of many individuals and organizations who helped organize our work and sponsor our activities. The members of the Commission are particularly indebted to the following for their assistance:

- American Academy of Pediatrics
- American College of Nurse Midwives
- American College of Obstetricians and Gynecologists
- American Hospital Association
- Burger King Corporation
- Center for Successful Child Development
- Citizens and Southern Bank
- The Coca-Cola Company
- Delta Airlines
- Georgia Power Company
- The Harris Foundation
- Johnson & Johnson
- The LBJ School of Public Affairs and the LBJ Library
- The Los Angeles Times
- March of Dimes Birth Defects Foundation
- Medical Association of Georgia
- NAACOG: The Organization for Obstetric, Gynecologic, and Neonatal Nurses
- National Congress of Parents and Teachers (PTA)
- National Perinatal Association
- Southern Bell Company
- The Pillsbury Company Foundation
- The United Nations, the U.S. Mission to the U.N., and UNICEF

A superb Technical Advisory Committee provided the Commission with the benefit of their knowledge and practical experience. We are deeply grateful for their assistance.

The Commission further acknowledges the outstanding work of the Commission's Executive Director, Rae K. Grad, and the staff: Mary Brecht, Deputy Director, Anne Hockett, Ann Mayhew, Kathy Allen, Lauren Arnold, Michael Smith, Betty Palmer, and Sharon Harbor.

THE NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

The Congress of the United States enacted legislation to create the National Commission to Prevent Infant Mortality in November 1986, and it was established in July 1987. The fifteen-member Commission includes Members of Congress, the Secretary of Health and Human Services, the Comptroller General of the United States, representatives of state governments, and experts in the field of maternal and child health.

Medical science already knows much of what needs to be done to achieve dramatic improvements in the health and survival rates of very young children. The Commission, therefore, focused its work on reviews of existing programs and policies directed at the health of women of childbearing age and their infants. This report is based on those reviews and on five hearings at which the Commission received expert opinion on how to proceed. The hearings focused on:

- **The Role of the Private Sector in Reducing Infant Mortality** gave the Commission the opportunity to hear how business and industry, along with religious and community groups, have a direct stake in promoting the health of the next generation of workers and consumers. Atlanta, Georgia. January 11, 1988.

- **International Strategies for Improving Maternal and Infant Health** provided information on how the people of other countries with successful experiences in reducing infant mortality attend to the health care needs of pregnant women and infants. New York, New York. February 1, 1988.

- **The Role of the Media in Public Policy** was discussed by a panel of experts at a third hearing which focused on how the media can move forward an issue such as children's health and thus change the priorities of the nation. Los Angeles, California. February 29, 1988.

- **The Government's Role in Reducing Infant Mortality** highlighted changes needed in federal and state government programs to better coordinate, finance, and deliver maternal and child health and related services. Chicago, Illinois. April 25, 1988.

- **Priorities for Reducing Infant Mortality** provided an opportunity for leaders in the field of maternal and child health to share with the Commission their insights and priorities for a national strategy to reduce infant mortality. Washington, D.C. May 20, 1988.

Throughout the year, the Commission published several special reports to explain aspects of the infant mortality problem:

Infant Mortality: Care for Our Children, Care For Our Future
Perinatal AIDS
Malpractice and Liability: An Obstetrical Crisis
Prevent Infant Mortality: A Resource Directory
The Private Sector's Role in Reducing Infant Mortality
The International Infant Mortality Perspective
Infant Mortality and the Media
1985 Indirect Costs of Infant Mortality and Low Birthweight

Finally, this report is accompanied by a supplemental volume of Issue Briefs on topics pertinent to infant mortality. The issues addressed include:

- Priorities for Reducing Infant Mortality in the United States: A Survey
- A History of Federal Initiatives To Reduce Infant Mortality
- Prenatal Care
- Low Birthweight
- Postneonatal Mortality
- The Financing of Maternity and Infant Care
- Title V Maternal and Child Health Services Block Grant
- Community and Migrant Health Centers
- The Special Supplemental Food Program for Women, Infants, and Children (WIC)
- Maternal and Child Health Provider Issues
- Minority Populations
- Adolescent Pregnancy
- The National Vital Statistics Program

Members of the Commission

Hon. Lawton Chiles
Chairman
United States Senate
Washington, D.C.

Hon. J. Roy Rowland
Vice Chairman
U.S. House of Representatives
Washington, D.C.

Hon. Otis R. Bowen, M.D.
Secretary of Health and Human Services
Washington, D.C.

Hon. Charles A. Bowsher
Comptroller General of the United States
Washington, D.C.

Hon. David F. Durenberger
United States Senate
Washington, D.C.

Herman A. Hein, M.D.
Professor of Pediatrics
University of Iowa
Iowa City, Iowa

William H. Hollinshead, M.D.
Rhode Island Dept. of Health
Providence, Rhode Island

Barbara D. Matula
North Carolina Dept. of Human Resources
Raleigh, North Carolina

Julius B. Richmond, M.D.
Harvard University
Boston, Massachusetts

Hon. Richard W. Riley
Columbia, South Carolina

Lynda Johnson Robb
McLean, Virginia

Hon. Thomas J. Tauke
U.S. House of Representatives
Washington, D.C.

Hon. James R. Thompson
Governor
Springfield, Illinois

Hon. Diane E. Watson
State Senate
Sacramento, California

Margaret S. Wilson
East Connecticut State University
Norwich, Connecticut

Rae K. Grad, R.N., Ph.D.
Executive Director

The National Commission to Prevent Infant Mortality

Switzer Building
Room 2006
330 C Street, S.W.
Washington, D.C. 20201
(202) 472-1364

BEST COPY AVAILABLE

Death Before Life:
THE TRAGEDY OF INFANT MORTALITY

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

☒ This document has been reproduced as received from the person or organization originating it.

☐ Minor changes have been made to improve reproduction quality.

● Points of view or opinions stated in this document do not necessarily represent official OERI position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Rae K. Grad
National Commission to Prevent Infant Mortality
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

The National Commission to Prevent Infant Mortality

August 1988

BEST COPY AVAILABLE

Death Before Life:

THE TRAGEDY OF INFANT MORTALITY

APPENDIX

The National Commision to Prevent Infant Mortality

August 1988

CONTENTS

Introduction 1

Priorities for Reducing Infant Mortality in the United States: A Survey 3

A History of Federal Initiatives to Reduce Infant Mortality 7

Issue Briefs:

- Low Birthweight 23
- Postneonatal Mortality 27
- Prenatal Care 33
- The Financing of Maternal and Infant Care 38
- Title V Maternal and Child Health Services Block Grant 56
- Community and Migrant Health Centers 62
- The Special Supplemental Food Program for Women, Infants, and Children (WIC) 70
- Maternal and Child Health Provider Issues 75
- Minority Populations 86
- Adolescent Pregnancy 100
- The National Vital Statistics Program 107

Introduction

In carrying out its mandate from Congress to develop a national strategy to reduce infant mortality, the National Commission to Prevent Infant Mortality identified several topics for detailed exploration and discussion. This appendix, which supplements the Commission's final report entitled *Death Before Life: The Tragedy of Infant Mortality* (August 1988), covers a range of topics that provide important background information on policies, programs, and issues concerning infant mortality and maternal and child health in the United States. Such information heretofore has not been available in any one document.

The first paper provides the results of a nationwide survey of maternal and child health experts who were asked to share with the Commission their top priorities for reducing infant mortality in America. In addition to this expertise, the Commission believed it was important to review the numerous federal and national efforts involved in reducing infant mortality over the course of this century so that planning for the future could be enlightened by lessons of the past. The second paper, then, is a historical overview of federal activities during the 1900s and the events of the day that influenced their development or demise.

Finally, a series of issue briefs explores various aspects of the infant mortality problem, pertinent federal and state programs serving pregnant women and young children, populations of particular concern, and related issues that must be addressed if any meaningful headway is to be made in improving the health of infants.

The National Commission has prepared this report appendix for federal, state, and local policymakers as well as other individuals in both the public and private sectors who are committed to improving the health and well-being of our nation's youngest and most vulnerable citizens.

PRIORITIES FOR REDUCING INFANT MORTALITY IN THE UNITED STATES: A SURVEY

PRIORITIES FOR REDUCING INFANT MORTALITY IN THE UNITED STATES: A SURVEY

The National Commission to Prevent Infant Mortality conducted a national survey to elicit from recognized experts in the field of maternal and child health their priority recommendations for reducing infant mortality in the United States. The survey was sent to a sample of groups and individuals working on issues related to maternal and child health. This sample included major national organizations and directors of state programs in maternal and child health and crippled children's services; Special Supplemental Food Program for Women, Infants, and Children (WIC); and Medicaid. Additionally, individuals known for their expertise in maternal and child health were surveyed. The results of this survey were incorporated where appropriate into the National Commission's final report to the Congress and the President.

The survey was mailed in March 1988 to 307 potential respondents.[1] When surveyed, they were asked to list three short-term and three long-term recommendations for reducing infant mortality in the United States.[2] (See attached survey.) Of the surveys mailed, 143 were completed and returned, representing a response rate of 47 percent. The respondents made a total of 742 recommendations (not every respondent made the requested six recommendations, while some made more). Responses came from 94 state officials, 24 organizations, and 25 individuals, representing 43 states and 2 territories, thus very much reflective of a national perspective.

SURVEY RESULTS

As the surveys were analyzed, six major themes emerged with several categories of recommendations under each. These themes were as follows:

- **Universal access** to maternity and/or preventive pediatric care was specifically recommended by almost half (45 percent) of the respondents as a priority recommendation for reducing infant mortality. Many of the detailed recommendations in this category reflected the urgency in providing all women and children the care they need.

- **Financial access** to maternity and/or preventive pediatric care was cited by almost all (91 percent) respondents. Over half (51 percent) recommended increasing Medicaid coverage and removing barriers to Medicaid eligibility for pregnant women and children, whereas some (10 percent) suggested a guarantee of private sector insurance coverage for maternity and child health services. Detailed recommendations centered around the need for increased funding in the Medicaid program (such as increasing the federal match for covered maternal and child health services), funding of WIC so that 100 percent of eligible individuals would receive services, and expanded funding for the Maternal and Child Health Services (Title V) program.

- **Access to maternal and child health care services** was a high priority for virtually all respondents (98 percent). The range of recommendations in this category was diverse. Almost one third cited the need to assure that high quality services are available and conveniently located for all mothers and children. At least one fourth of all the respondents suggested either expanding or improving WIC programs, case management and outreach services to populations at risk, the supply and distribution of qualified maternal and child health providers, and family planning services.

- **Education and public awareness** about the problem of and strategies to reduce infant mortality was recommended by more than half (59 percent) of respondents. The survey analysis reflected that a central theme throughout was the need for more education and awareness in our schools and among the general public. More than one fourth of the respondents suggested mounting a national media campaign to inform people of care they need and how to access that care. In addition, almost half of those responding recommended that family life education programs should be widely available in schools, beginning in the early educational years.

- **Research and data needs** to reduce infant mortality were also delineated. It was recommended that research efforts to identify the causes of infant mortality and low birthweight continue, and that review panels be established at the local level to investigate each infant death. Additionally, it was recommended that the system for collecting data on infant mortality be improved.

- **Increasing the value placed on children and families by society** was a concern for many of the respondents. These recommendations focused on societal changes, such as the need to address poverty, housing, substance abuse, and self esteem among our young people. In addition, parental work leave programs were recommended for families in need.

More detail on these recommendations is included in table 1.

CONCLUSION

The Commission's national strategy for reducing infant mortality was devised not by doing primary research but rather from drawing on the decades of experience and expertise both in this country and abroad. This survey of the Maternal and Child Health community was part of that effort.

The respondents' priority recommendations were remarkably similar in that they all called for (1) mechanisms that would move the United States closer to universal access to needed comprehensive health care services for all pregnant women and young children and (2) increased public awareness for the magnitude of the problem and the societal and economic ramifications if left unsolved.

NOTES

1. The survey was also sent to all Members of Congress. Because of the low response rate (six surveys were completed and returned), the numbers are not included in the overall sample size and response rate. Their responses were, however, fully considered by the National Commission in its deliberations.

2. The short-term and long-term recommendations were collapsed after analysis revealed no significant distinctions between the two categories.

Table 1
Survey Results: "What are your recommendations for reducing infant mortality in the United States?"

Recommendations	Respondents	
	No.	*Percent*
Universal Access to Maternity and Preventive Pediatric Care	65	45
Financial Access to Maternal and Child Health Services	130	91
Increase Medicaid coverage and remove barriers to eligibility for pregnant women and children	73	51
Guarantee private sector insurance coverage for maternity and child health services	15	10
Assure Access to Maternal and Child Health Care Services	140	98
Expand WIC	50	35
Assure that quality services are available and conveniently located for all mothers and children	44	31
Expand case management and outreach services to populations at risk	43	30
Expand and improve family planning services	38	27
Assure adequate supply and distribution of qualified maternal and child health care providers	38	27
Expand and improve prenatal care services	26	18
Expand and improve infant and early childhood services	25	17
Expand social support services	11	8
Education and Public Awareness	84	59
Expand and improve "family life" education	60	42
Launch a national public education campaign about the problems of infant mortality and solutions	38	27
Educate mothers about healthy behaviors and lifestyles during pregnancy	30	21
Research and Data Needs	22	15
Identify and investigate the causes of infant mortality	12	8
Investigate the causes of SIDS	6	4
Establish expert review panels at the local level to investigate each infant death	3	2
Improve the vital statistics collection system	2	1
Increasing the Value Placed on Children and Families by Society	28	20
Launch a sustained war on poverty	22	15
Allow parents leave from work upon the birth or sustained illness of a child	8	6
Promote values which emphasize the importance of children	7	5

Note: A total of 742 recommendations were submitted to the National Commission to Prevent Infant Mortality by 143 respondents.

National Commission to Prevent Infant Mortality

Room 2006, 330 C St. SW Washington, D.C. 20201 (202) 472-1364

Survey of Priorities
for Reducing U.S. Infant Mortality

Please complete this survey by writing in the space provided your top three short and long range goals/recommendations for reducing infant mortality in the United States. You are welcome to include additional supporting materials if you would like.

Thank you for your assistance. Please return by April 15, 1988.

What are your short term recommendations for reducing infant mortality in the United States?

1.

2.

3.

What are your long term recommendations for reducing infant mortality in the United States?

1.

2.

3.

Please provide your name, address, and telephone number so we may contact you for any questions we may have:

Name:

Address:

Telephone:

A HISTORY OF FEDERAL INITIATIVES TO REDUCE INFANT MORTALITY

A HISTORY OF FEDERAL INITIATIVES TO REDUCE INFANT MORTALITY

Throughout the twentieth century, American society has repeatedly affirmed its concern for the health and well-being of its mothers, infants, and children. Over the decades, numerous governmental agencies and interested groups of health care professionals as well as private citizens have made recommendations to improve health care for mothers and infants and to reduce infant mortality. As a result, state and federal programs were created to provide needed services to mothers, infants, and children, and existing programs have been modified to improve the services they offered. Historically, the creation of these services was influenced by public opinion and attitudes, social movements, political forces, scientific developments, and other major events of the time.

This historical account of federal initiatives to reduce infant mortality and notable events in the development of maternal and child health programs in the United States begins at the turn of the century when the public first began to express its active interest in the health of mothers and infants. Individuals and groups began to advocate for federal involvement in developing and administering maternal and child health care services and, for the first time, public investment was made in providing these needed services. This account continues to develop over the course of this century and ends with the beginning of 1980.

HISTORICAL THEMES

The history of federal initiatives to reduce infant mortality reveals several themes which have recurred throughout the twentieth century. They are:

- **Prenatal care** beginning in the first trimester has long been considered effective in reducing infant mortality, particularly infant mortality occurring in the neonatal period (before the first month of life). Prenatal care is defined as: "health status evaluation and health promotion activities, biomedical, obstetrical, psychosocial and environmental risk assessment, as well as diagnosis and treatment of identified problems from the time conception is initially considered until labor begins." [1] Over time, beginning with the first report issued in 1909, [2] the value of prenatal care in reducing infant mortality has been a recurring theme in the scientific literature and in reports of various private and public sector commissions and panels.

- **Federal coordination** of health care services for mothers and infants has been considered essential in assuring access to and quality of those services. Around 1900, it was first suggested that a Children's Bureau should be established so that a federal organization would be responsible for the overall coordination and investigation of the health of children. The Children's Bureau was established in 1912. Since that time, various recommendations have been made to expand and improve federal coordination of maternal and child health services. In fact, recent reports issued in the 1980s continue to reiterate that same theme.

- **Comprehensive services**, including medical care for mothers and infants, social support for the expecting family, nutrition education and services, and other patient education by qualified professionals is necessary to reduce infant mortality because infant mortality is caused by many and varied health, environmental, and behavioral factors. Comprehensive services are recognized as effective in improving the health and well-being of mothers and infants, while programs which offer less than comprehensive services are incomplete and often ineffective. The first White House Conference on Children, convened in 1909 by President Roosevelt, emphasized the importance of comprehensive health services for mothers and infants and recognized the importance of the family. [3] The most recent White House Conference on Children, convened in 1970 by President Nixon, also stressed the importance of comprehensive health services for mothers and infants. [4]

These themes which have been highlighted and discussed by many groups and individuals at all levels, including the highest level of government, have remained consistent over the course of this century: the need for prenatal care, the importance of federal coordination of health services for mothers and infants, and the necessity of comprehensive services. Many aspects of these themes have been put into practice and, as a result, the infant mortality rate has dropped dramatically since 1900, from a rate of 150 infant deaths per 1,000 live births to a 1985 rate of 10.6.[5] However, in recent years, progress in reducing infant mortality has come to a virtual standstill, and concerned groups and individuals assert that we are not doing as much as we can as a nation to prevent unnecessary infant deaths. Therefore, this historical account is presented so that the current problem of infant mortality can be considered in the context of what was done in the past to reduce unnecessary infant deaths.

- It is useful to evaluate today's infant mortality problems from a historical perspective so that we might learn from the successes and mistakes of the past and develop an effective plan for preventing infant mortality for the future.

- "*The infant of today will be the citizen of the future. It behooves us then to give first place to the care and well-being of our nation's greatest asset,*" according to Stewart G. Thompson, D.P.H., Director, Bureau of Vital Statistics, Florida State Board of Health, 1921.[6]

THE EARLY YEARS: THE TURN OF THE CENTURY

During the latter part of the nineteenth century, public opinion and attitudes about children began to change. From seeing children as small adults and cheap labor, society began to realize that if babies were to survive into childhood and children into adulthood, their health needed to be protected.[7] Pediatrics grew as a distinct branch of medicine, scientific developments began to address the unique needs of children, and serious concern developed for the high mortality and morbidity (illness) rates of infants.

As early as 1849, infant mortality statistics were collected in small regions and were then considered, as they are today, to be indicators of sanitary conditions. The value of collecting infant mortality rates was highlighted in England by Sir Arthur Newsholme in his frequently cited statement: "*Infant mortality is the most sensitive index we possess of social welfare and sanitary administration, especially among urban conditions.*"[8]

- In New York City, the infant mortality rate was reported to be approximately 180 infant deaths per 1,000 live births in 1850.[9]

- In 1900, data from 10 states and the District of Columbia indicated that approximately 15 percent of all live born infants died before their first birthday, which was an infant mortality rate of 150 infant deaths per 1,000 live births.[10]

The collection of vital statistics was very incomplete at this time; therefore, all reported infant mortality rates before 1927 are considered to be approximations. At the turn of the century, major efforts were made to establish a national registry for the compilation of vital statistics, including births and infant and maternal deaths. The collection of vital statistics was considered to be essential. Proponents of a national registry stated that "vital statistics are needed so that we can determine the causes of infant death so that preventive measures can be instituted...whether they are prevention of prematurity through prenatal care...treatment of infant infections, management of hard labor and delivery, or improvement of the (infant's environment)."[11] Continued efforts to improve the collection of vital statistics resulted in the establishment of the National Birth Registry in 1915.

The industrial revolution and urbanization of America created environmental and economic problems for children and infants, and unprecedented attention began to be directed toward their problems and needs. The movement to improve maternal and child health in the United States emerged from a serious and sustained concern about the exceedingly high rates of infant death occurring around the turn of the century. Many of the ideas and practices implemented to reduce infant mortality in this country, such as prenatal care, were borrowed from France, England, and other European countries.[12]

Among those looking to other countries for guidance was the first organization of health care professionals to advocate for maternal and child health, The American Association for the Study and Prevention of Infant Mortality, founded in 1909. Its purpose was to study the problem of infant mortality, to make recommendations to prevent infant mortality, and to increase public awareness about the problem of infant mortality and its consequences. (Successor organizations of the Association were the American Child Hygiene Association, 1919, and the American Child Health Association, 1923).[13]

The Association recommended initially and in subsequent annual meetings the following strategies for the reduction of infant mortality: measures and activities on which special emphasis should be laid are the complete registration of vital statistics; greater insistence on breastfeeding; better training of physicians for the practice of obstetrics; the enforcement of standard rules for the control of milk, with full publicity with respect to good and bad milk supplies; the pasteurization of all doubtful milk; the registration, instruction, and control of midwives; prenatal care for expectant mothers; and the work of the visiting nurses and social workers, among other strategies.[14]

The Beginning of Organized Prenatal Care

An organized system of prenatal care in the United States was introduced in Boston by nurses of the Instructive District Nursing Association. (Previously, prenatal care was provided informally, with casual advice given by friends or family members of the pregnant woman or by her physician, midwife, or nurse). By 1906, all patients enrolled in the home delivery service of Boston Lying In Hospital were visited by a nurse at least once during pregnancy for the purpose of educating the expectant mother about appropriate care for herself during pregnancy and delivery. In 1909, the Instructive District Nursing Association developed an intensive prenatal care program for women with special health care needs. Women were visited every 10 days by a nurse who provided instruction on self-care, emotional support, and appropriate health care. This work was deemed a success and stimulated the development of an outpatient clinic for the provision of prenatal care in 1911. Pregnant women were urged to attend this clinic early and regularly.[15]

The contribution of prenatal care services to the reduction of infant mortality began to receive attention from health care professionals and the general public. Scientific writings of the time started to link prematurity to prenatal causes and, in fact, some boldly stated that prenatal care might be effective in reducing preventable infant mortality. One of the first scientific investigations about prenatal care was conducted at Johns Hopkins Hospital by J.W. Williams in 1914. He estimated that the infant mortality rate among 10,000 consecutive admissions could have been reduced by 40 percent with organized prenatal care.[16]

The Beginning of Public Responsibility for Reducing Infant Mortality

The establishment of the New York Division of Child Hygiene in 1908 by Josephine Baker, M.D., and a nurse, Lillian Wald, marked the first attempt to consolidate public health efforts to reduce infant mortality in the United States.[17] Among its many programs was one in which the mother of each newborn in New York's Lower East Side was visited by a public health nurse and taught the principles of infant feeding and baby care. During the first summer of operation, 1,200 fewer infants died compared with the previous summer.[18] The Bureau also conducted child health clinics and later extended its programs to encompass the provision of prenatal and labor and delivery care.

Establishment of the Federal Children's Bureau

The burgeoning awareness of the social problems causing high rates of infant mortality lead to the public's recognition that, in order for infant mortality reduction initiatives to be effective, the federal government must assume broad national responsibility for those initiatives. In 1909, a nationwide conference was held to examine the health and welfare of children in the United States. This meeting of some 200 health care professionals and interested private citizens was convened by President Theodore Roosevelt and came to be known as the White House Conference on Children. It was the first in a series of conferences to be convened each decade by the White House to focus national attention on children's issues and their potential solutions.

The conference recommended the establishment of the United States Children's Bureau, which would investigate and report on child health and welfare. Vigorous debate ensued about the establishment of the Children's Bureau. Opponents debated federal involvement in what was perceived to be a private issue, the health and well-being of children. They opposed government meddling in the domain of parents. On the other side, advocates argued that federal coordination of child health initiatives was essential for the improvement of the health and welfare of America's children. In a message to the Congress, delivered on February 15, 1909, President Theodore Roosevelt stated:

"It is not only discreditable to us as a people that there is now no recognized and authoritative source of information upon subjects relating to child life, but in the absence of such information as should be supplied by the Federal Government many abuses have gone unchecked; for public sentiment, with its great corrective power, can only be aroused by full knowledge of the facts." [19]

After vigorous debate, on April 9, 1912, President William Taft signed legislation creating the Children's Bureau. The mission of the Children's Bureau was to "investigate and report on all matters pertaining to the welfare of children and child life among all classes of people and shall especially investigate the questions of infant mortality, the birth rate, orphanages, juvenile courts, desertion, dangerous occupations, accidents and diseases of children, employment, and legislation affecting children in the several states and territories." [20]

Early activities of the Children's Bureau included:

- A report which emphasized the importance of birth registration, proclaiming it as "the starting point for the reduction of infant mortality by identifying infants at risk for health problems, or of dying." [21] As a result of this report and other activities, in 1915 the National Birth Registry was established.

- "Baby-saving Campaigns," [22] a 1914 report which presented model programs for maternal and child health. This report proposed complete birth registration, prenatal care, competent attendance at birth, encouragement of breastfeeding, medical supervision of children, and access to a clean milk supply.

- The second year of World War I being designated "Children's Year" with the approval of President Woodrow Wilson. This national campaign advocated for the improvement of care for mothers prenatally and during childbirth. President Wilson, in announcing the campaign, declared that, *"Next to the duty of doing everything possible for the soldiers at the front, there could be, it seems to me, no more patriotic duty than that of protecting the children who constitute one-third of our population."* [23]

The Second White House Conference on Children

The second White House Conference on Children was convened by President Woodrow Wilson in 1919 as the culmination of the Children's Year Campaign. During World War I, the Children's Bureau had struggled to ensure that certain basic standards for the health and welfare of children were maintained. When the War ended, the White House Conference was convened for the purpose of establishing these standards on a firmer basis. Proposals setting minimum standards for the health care of mothers and children were made for the first time by the federal government. The conference proceedings were the precursor of the Maternity and Infancy Act, also known as the Sheppard-Towner Act.

The Sheppard-Towner Act, 1920 to 1929

The legislation that established the Children's Bureau mandated that it help state and local groups take appropriate action to improve the care of pregnant women, infants, and children. [24] The early studies which demonstrated the relationship of social and economic factors to the medical causes of infant death, provided the basis for the Children's Bureau to propose and justify a continuing grants-in-aid program to assist state health agencies to establish and improve services to promote the health of mothers and infants. [25]

As a result of these findings and the success of the programs implemented by the Bureau, as well as the recommendations of the second White House Conference on Children, legislation was proposed for the Maternity and Infancy Act, which was enacted by the Congress in 1921. Also known as the Sheppard-Towner Act, it provided grants to states to develop health services for mothers and infants and was the first public health grants-in-aid program enacted in the United States, thus establishing the precedent for public responsibility for maternal and child health. [26] The program granted matching funds to the states for the provision of services, including prenatal care, well-baby and well-child care, parent education, birth registration, and education of nurses and physicians. In the 8 years of its existence, the Sheppard-Towner Act brought many improvements in health services for mothers and infants.

- Birth registration increased from 30 states in 1920 to 46 states in 1929, encompassing 95 percent of the national population.[27]
- The number of state child hygiene divisions increased from 28 to 47, the number of permanent maternal and child health centers increased greatly with 1,594 being established between 1924 and 1929, and public health nursing services expanded.[28]
- The benefits of a new partnership of federal and state governments in promoting the health of mothers and children were demonstrated, a theme to be repeated in future decades.[29]

Although maternal and child health services improved under the Sheppard-Towner Act, opposition to the act was strong. It was assailed and opposed in the Congress as "socialistic," and denounced as "drawn chiefly from the radical, socialistic, bolshevistic philosophy of Germany and Russia."[30] The American Medical Association labeled it a socialistic scheme, while others denounced it as a move toward eliminating racial discrimination because, under the act services were required to be available for all residents of the state. By 1929, those opposing the Sheppard-Towner Act succeeded and the act was repealed.

Despite efforts to curtail public involvement in maternal and child health, the American Association for the Study and Prevention of Infant Mortality continued to encourage its members to improve health services for mothers and infants. The limited role of health departments began to grow, and more broadly trained personnel became available as schools of public health began to organize (1918 to 1923).[31]

The Children's Bureau also continued its many projects, one of which was to publish, in 1924, a report entitled *Prenatal Care*.[32] An important finding was that of those infants who died before the age of 1, 42 percent died within the first month of life. Events occurring during pregnancy, such as inadequate nutrition and poor maternal health, were regarded as the causes of these infant deaths. The Bureau issued a strong statement about the importance of early and continuous prenatal care. In 1925, *Standards of Prenatal Care*[33] was published by the Bureau outlining what should be included in the content of prenatal care. It stressed the importance of early identification of problems which might adversely affect the outcome of pregnancy, and recommended interventions to reduce or eliminate these problems.

The Children's Bureau conducted the first extensive study on maternal and infant mortality in the United States in 1927 and 1928. Findings from that study and a later (1929) collaborative investigation with Yale University emphasized that early and continuous prenatal care was important in preventing maternal and infant deaths. The authors stated: "*more careful prenatal care...would probably reduce the number of premature deliveries, there is little doubt that many premature infants' lives would be saved if modern methods of care were available in every community.*"[34]

Another important investigation conducted by the Children's Bureau was on maternal mortality.[35] In contrast to the steady and marked decline in infant mortality, the maternal death rate remained at a high level. As a result of this study, the Bureau issued a series of recommendations, to the medical profession and to the general public, which were influential in preparing the way for the great improvements made in maternity care in the following years. The series of guidelines included recommendations for implementing early and continuous prenatal care and stressed the importance of comprehensive health care and social supports.

THE DEPRESSION YEARS: 1930 to 1940

The decade of the 1930s was ushered in by an industrial depression during which child welfare workers were overwhelmed by the suffering among children and their families. With Sheppard-Towner Act funds gone, health services for mothers and infants in need were drastically reduced. Therefore, in 1929, President Herbert Hoover convened the White House Conference on Child Health and Protection "to study the present status of the health and well-being of children in the United States and its possessions; to report what is being done; to recommend what ought to be done and how to do it."[36]

The final product of the conference consisted of 32 volumes of conference proceedings, findings, and recommendations. Of these volumes, the most impressive document was the Children's Charter. Endorsed by the conference, it contained 19 statements as to what every child needs for his education, health, welfare, and protection. It expressed the aspirations of the nation for its children in words that are still vibrant and meaningful today. This statement of the fundamental rights of children included two aims for the health of children.[37] They are:

- "For every child full preparation for his birth, his mother receiving prenatal, natal and postnatal care; and the establishment of such protective measures as will make childbearing safer."
- "For every child health protection from birth through adolescence, including: periodic examinations, and where needed, care by specialists and hospital treatment."

The recommendations of the Conference stressed the importance of treating the child as an individual and of viewing his developmental, health, and social needs in total rather than fragmenting them among specialized services. Many of these recommendations formed the basis for the provisions of Title V of the Social Security Act which was to be enacted in 1935.

Title V of the Social Security Act

The depression depleted funding for federal, state, and privately supported maternal and child health programs. By 1934, 9 states no longer funded programs and 23 states had substantially reduced appropriations for such services.[38]

Concerned about addressing the health and welfare needs of the nation's children, the Economic Security Committee (established to make recommendations to the President on issues of employment and economic security) consulted with the Children's Bureau to develop strategies for implementing needed health and welfare programs. The recommendations formed the basis for making additions to Title V of the Social Security Act to include programs for the protection of the health and well-being of mothers and infants. Several forces influenced the enactment of Title V of the Social Security Act.[39] They are:

- The increasing recognition of the responsibility of the federal government for the promotion and protection of the well-being of children, which was earlier demonstrated with the establishment of the Children's Bureau and passage of the Sheppard-Towner Act.
- Evidence provided by the Children's Bureau that far greater needs had existed for services than had been generally realized. The report of the President's Committee on Economic Security summarized some of this evidence, pointing out that resources for the care of the handicapped were virtually nonexistent in rural areas, that the maternal mortality rate in the United States was much higher than in other countries, and that many states appropriated virtually no funds for maternal and child health services.[40]
- Recognition that a program for recovery from the depression should include not only measures to assure adequate income but also measures to promote health.

It was therefore recommended by the President's Committee on Economic Security that substantial grants-in-aid to state and local health departments be provided to support a nationwide program for the extension of public health services.[41] In 1935, when the legislation establishing Title V of the Social Security Act was proposed, the nation was ready for a new program for maternal and child health. On August 14, 1935, President Franklin D. Roosevelt signed the Social Security Act into law. It was adopted with bipartisan enthusiasm.

Title V of the Social Security Act was composed of three parts:

- Maternal and Child Health Services
- Services for Crippled Children
- Child Welfare Services

Modeled after the Sheppard-Towner Act, Title V authorized federal grants to states for the provision of prenatal care, well-baby clinics, school health services, immunizations, public health nursing services, nutrition services, and health education. Some of the most important innovations to come from Title V programs resulted from demonstration projects. A number of demonstration projects were designed to improve pregnancy outcomes by improving prenatal care and increasing access to care for rural women. In addition, programs to address the needs of premature infants were initiated which provided special training for nurses and physicians. Title V remained essentially unchanged until 1963. The success and continuity of these activities indicated that, in fact, the federal government's role in the provision of health services to mothers and infants is necessary.

The Children's Bureau, as the administrator of Title V programs, continued research-related activities on infant mortality and began to make efforts to identify populations especially in need of targeted efforts to improve the health of its mothers and infants. While impressive progress had been made in reducing the rate of infant mortality up to this time, 60 infant deaths per 1,000 live births remained unacceptable particularly because it was felt that many of those infant deaths were preventable. [42] As more research was done on infant mortality, great disparities between rates for whites and blacks were discovered.

- In 1937, the Children's Bureau published one of the first reports about infant mortality in a vulnerable population. *Infant and Maternal Mortality among Negroes*[43] brought to national attention the fact that infant deaths among the black population occurred at substantially higher rates than in the white population.

- In 1935, the infant mortality rate for nonwhite infants was 83.2, compared to a rate of 51.9 for white infants. Recommendations were made to "bring Negro mothers safely through childbirth and infants through the first year of life." [44]

THE WAR YEARS: 1940 TO 1950

By 1940, the U.S. infant mortality rate had fallen to 47.0 infant deaths per 1,000 live births. [45] Discrepancies between black and white infants remained, however, with the rate for black infants nearly twice that for whites (73.8 compared with 43.2 for white infants), a situation that has remained largely unchanged to date. [46]

The Fourth White House Conference on Children

Building on the need to identify high-risk populations, the White House Conference on Children of 1940 opened the decade with a focus on children in vulnerable situations. This Conference was held during the first year of World War II and about 1 year before the United States entered the war. Recovery from the great depression was essentially complete, with many more people employed. During this time, world tensions were rising, and defense and related industries were expanding. The conference, convened by President Franklin D. Roosevelt, focused on social and economic matters and their effects on children.

In his opening remarks to the conference participants, President Roosevelt stated:

> *"All Americans want this country to be a place where children can live in safety and grow in understanding of the part they are going to play in the future of our American Nation...If anywhere in the country any child lacks the opportunity for home life, for health protection, for education, for moral or spiritual development, the strength of the Nation and its ability to cherish and advance the principles of democracy are thereby weakened."* [47]

At the conclusion of the conference, recommendations called for the expansion and improvement of services for children and attention was drawn to inequalities in access for different populations. As stated by a conference participant:

> *"It has become abundantly clear that as one goes down the economic scale, sickness increases and medical care declines...it will be very bad economy to save money at the cost of the minds and the bodies of the children of this country. We cannot afford to let things rest as they are."* [48]

During World War II, the need for maternity services by wives of servicemen overtaxed military hospitals. To alleviate the situation, the Emergency Maternity and Infant Care Act was passed in 1943, providing maternity care and well-baby care at no cost to wives of servicemen in the four lowest pay grades. The act ended in 1949, after the end of the war, and was considered a great success. Through its administrative efficiency, improvement in the quality of maternity care and further reduction of infant mortality rates were accomplished by providing care to those who might not otherwise have received it. In 1956, the Dependents Medical Care Act restored the programs, and, in 1966, it was incorporated into the Civilian Health Medical Program.

Despite the disruptions of the war years, steady progress was made in the period 1940 to 1945 in reducing maternal and infant mortality.

- The maternal mortality rate for the year 1945, 20.7 deaths per 10,000 live births, was the lowest ever recorded a decrease from 37.6 in 1940.[49]
- The infant mortality rate declined from 47 in 1940 to 38.3 in 1945.[50]

Although the reduction in maternal and infant deaths was encouraging, an analysis conducted by the Children's Bureau showed that discrepancies still existed in some populations. A study of neonatal deaths (those occurring in the first month of life) revealed that, while overall infant death rates declined by 29 percent from 1935 to 1944, neonatal death rates declined by only 24 percent in that same period.[51]

- 62 percent of all infant deaths in 1944 occurred when the infant was less than 1 month of age. Infant deaths occurring in the first month of life were known to be linked to problems encountered by the infant as a fetus and during the birth process.[52]
- Once again it became clear that in order to reduce preventable infant deaths, the health of pregnant women had to be improved through the provision of accessible, high quality, and comprehensive prenatal care services.

In 1946, the Children's Bureau was transferred from the Department of Labor to the newly created Federal Security Agency, where it was placed in the Social Security Administration. The Federal Security Agency later became the Department of Health, Education, and Welfare in 1953.

During the years following the war, the nation as a whole began to return to lifestyles approaching normal once again. During this period, major shifts in populations occurred. Blacks moved in large numbers from the rural South into the cities. At the same time, suburbia was developing, and a clear contrast in socioeconomic characteristics of the different communities emerged. As a result, the numbers of qualified nurses and physicians to provide obstetrical services to women and infants residing in urban locations was reduced. Compounding this problem was the substantial increase in the birth rate following the war (now popularly characterized as the post-war baby boom).

MIDCENTURY: 1950 to 1960

The decade was ushered in with the Midcentury White House Conference on Children and Youth. Convened by President Harry S. Truman in 1950, the Conference symbolized a nationwide effort to deal with one of the most important problems of the decade: how to develop in children the mental, emotional, and spiritual qualities essential to individual happiness and responsible citizenship. The question was posed, "what physical, emotional, and social conditions are necessary to this development?"[53] The conferees issued 67 recommendations for the health, emotional, and social development of children toward this end. The conferees called for a ban on racial segregation in public school and a ban on discrimination in child health and welfare services. One conference attendee pointed out that:

> *"While American incomes are high and rising, many children are born into economically substandard families, and the majority of them live in areas with the least wealth and the fewest services. Any economic investment of funds in our youngsters today will maintain the greatness of our nation."*[54]

During this decade, states and localities extended and broadened their health service programs to mothers and infants under the administration of the newly created Department of Health, Education, and Welfare. While the Title V maternal and child health programs remained primarily ones of preventive health services, many state health agencies started to provide medical and hospital care for low-income women lacking private resources to pay for their care, including care for mothers with complications of pregnancy and hospital care for premature infants.

The principle developments during the decade were the increase in programs for the treatment of children who were mentally retarded and for the care and treatment of premature infants. Special projects for the care of premature babies pioneered work in saving the lives of these undersized and underdeveloped infants, who weigh less than 5-1/2 pounds (2,500 grams) at birth. States were also giving greater attention to prenatal care, particularly for mothers with complications of pregnancy, in an effort to reduce the incidence of

60

prematurity. Progress was made in the specialized training of nurses and physicians to provide the increasingly complex health care required by mothers and infants. Despite these efforts, infant mortality was still far too high in many locations and for certain minority populations.

Infant Mortality in Urban Areas

In the 1950s and early 1960s, a large number of low-income, severely disadvantaged families migrated from the South to northern cities. Many of these families had great need for health services but had inadequate resources to pay for them. They placed enormous demands on the health and hospital services of the cities. At the same time, many middle- and higher-income families were moving to the suburbs. The resources in the large cities were becoming depleted, and health agencies found it difficult to provide the quantity of services needed to meet the increasing demand. A marked slowing in the decline of infant mortality in the United States occurred during the 1950s.[55]

- In 1950, the infant mortality rate for the United States was 29.2. It decreased in very small increments until 1954 when for the next 6 years, until 1960, the rate hovered around 26.4. (This pattern was to be repeated again in the 1980s.)[56]
- Neonatal mortality worsened by about 3 percent annually, both in 1957 and 1958.[57]

This break in progress in conserving infant lives was of great concern to those administering maternal and child health programs and was attributed to the increasing birth rate (the post-war baby boom) and the decreasing availability of qualified practitioners to provide needed health services for mothers and infants in inner city settings, leaving many mothers and infants with no access to quality health care. Several studies demonstrated an association between lack of prenatal care and increased neonatal mortality.

THE GREAT SOCIETY: 1960 to 1970

The decade beginning in 1960 saw the introduction of the Great Society programs. Poverty became an area of concern, and civil rights issues were paramount in the minds of many policymakers and the general public. Society was awakened to inequalities in all areas of life, including the health care system. The years 1957 to 1962 brought the problems of certain groups of children to the attention of the Children's Bureau's grant-in-aid programs. Among these were the adolescents, children of migrant workers, children of Native Americans, and mentally retarded children.

The 1960 White House Conference on Children

The 1960 White House Conference on Children and Youth was convened by President Dwight D. Eisenhower. The stated purpose of the conference was "to promote opportunities for children and youth to realize their full potential for a creative life in freedom and dignity."[58]

Some 7,600 conference delegates addressed problems of children and youth, including the problem of infant mortality. It was once again noted that discrepancies in infant mortality rates existed among geographic and ethnic distributions of the population. Access to care for vulnerable populations was a major area of concern. The conference ended with over 1,000 specific recommendations being made to almost every conceivable type of organization and individual having a bearing on the lives of young people: the President, the Congress, federal agencies, state and local governments, specific industries, the various helping professions, social and health agencies, religious institutions, schools, community planners, police, courts, housing officials, adults in general, parents, the family, and young people themselves.

The theme of this conference and its subsequent recommendations influenced major changes in maternal and child health programs in the 1960s. The Conference also served to increase the momentum throughout the nation for improving conditions of children.

The President's Panel on Mental Retardation

In 1961, the President's Panel on Mental Retardation was appointed by President John F. Kennedy to prepare a national plan to combat mental retardation. It found that the prevalence of mental retardation was most heavily associated with inadequate prenatal care and premature delivery of infants. The panel further noted that:

"Thousands of women of low income, especially those in the cities, are giving birth prematurely at two to two and one-half times the expected rate, that low birth weight babies are likely to have brain damage, that these women have excessive rates of complications of pregnancy, and that between one-fourth and one-half of the women in low-income families of our large cities delivered having had late or no prenatal care." [59]

In 1963, President Kennedy told the nation:

"Lack of prenatal and postneonatal health care in particular, leads to the birth of brain-damaged children or to an inadequate physical and neurological development. Areas of high infant mortality are often the same areas with a high incidence of mental retardation. Studies have shown that women lacking prenatal care have a much higher likelihood of having mentally retarded children." [60]

Programs Established in the 1960s

Based on recommendations from many sources including the Children's Bureau, the 1960 White House Conference on Children and Youth, and the President's Panel on Mental Retardation to name a few, major changes in maternal and child health programs occurred in the 1960s.

1963 amendment to Title V of the Social Security Act creating the Maternity and Infant Care Program (MIC). The stated objectives of this program are "to reduce maternal and infant mortality and morbidity by assisting communities in organizing their maternity and infant care services; to increase the accessibility of care; to improve the quality of care; and to make use of the best available resources in providing comprehensive maternity and infant care for low-income high-risk patients." [61]

MIC projects were established in areas of greatest need, where the infant and maternal mortality rates were highest and where there was a high concentration of low-income families, predominantly urban settings. Cities were targeted for these services because in the decade 1950 to 1960, many major cities had experienced an increase in infant mortality rate. In fact, during that time, infant mortality increased by 19 percent in Baltimore, which was representative of the trend in most major cities. [62] The maternity and infant care projects (the first was in Baltimore) provided prenatal care, hospitalization, delivery, and postpartum care as well as family planning services. Many of these programs are still in existence today.

1965 Amendments to Title V authorizing grants for children and youth projects. These projects provided comprehensive health care for children in low-income areas and included both direct medical care and preventive health services. They also provided screening, diagnosis, prevention services, treatment, correction of defects, and follow-up care for children. The projects funded under the Children and Youth Programs were designed to provide needed services and to be of high quality.

Both of these amendments were widely accepted. Public opinion seemed to indicate that people no longer wanted to accept two standards of health care, one for the poor and one for the affluent. [63] A significant provision of both amendments was to authorize comprehensive care, from case finding to direct health care services.

Title XVIII and Title XIX of the Social Security Amendments establishing Medicare and Medicaid (1965). Medicaid was designed as a medical assistance program to improve access to health care services for low-income Americans who are aged, blind, disabled, or members of families with dependent children. Although jointly funded by the federal and state governments, Medicaid is administered by the states and offers entitlement to a basic set of health services for people meeting eligibility criteria. Although the Medicaid program covers many low-income women and children, it was not specifically intended to improve pregnancy outcomes and reduce infant mortality.

The combination of MIC and Medicaid provided a system which combined clinical resources for the health care of women and infants with a mechanism to finance medical care. This combination has been considered to reflect the "first time that both the Legislative and Executive branches of the federal government made clear the important principle that there are two essential elements in any system of medical care: the financing of medical care, and the availability of clinical resources from which care can be provided and purchased." [64]

Comprehensive Neighborhood Health Centers (1965). Created under the Office of Economic Opportunity and as a part of the Partnership for Health Act, these centers provided family-focused health care in numerous communities across the country. This program was transferred to the Public Health Service in 1971 and is now known as the Community Health Centers program.

The Migrant Health Program (1965). This program was developed to provide an adequate level of health care to this underserved target population. Prenatal care and infant care services, among others, are provided to migrants, seasonal farm workers, and their families under this program.

Special Supplemental Food Program for Women, Infants, and Children (WIC), as an amendment to the Child Nutrition Act (1966). Administered by the Department of Agriculture, WIC provides nutritious food and nutrition education and also enhances access to health care services for eligible pregnant and nursing women and to children under 5 years of age. It became operational in 1972.

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program for needy children (1967). The Medicaid statute was amended to create the EPSDT program, and it was implemented in 1971. All states must offer EPSDT services to children eligible for Medicaid. The purpose of the program, as its name implies, is to provide children with periodic physical and developmental examinations as well as treat illnesses and conditions.

From the rather depressing infant mortality statistics presented from the 1950s and early 1960s, there was a sudden change in 1966 when the rate dropped to 23.7 infant deaths per 1,000 live births, representing a decrease of 4 percent over the previous year. The rate for 1967 was 22.4. In those 2 years, the infant mortality rate had decreased twice as much as in the entire previous decade.[65]

In 1969, the Children's Bureau was dismantled, despite its long history of action on behalf of mothers and infants and relative success in improving the health and welfare of children. Under the reorganization of the Department of Health, Education, and Welfare, health grants from the Children's Bureau were transferred to the Public Health Service, and what was left of the Children's Bureau was subsumed under the newly formed Office of Child Development. The dissolution of the Children's Bureau eliminated what many believed to be the very effective voice representing mothers, infants, and children in the federal government. One commentator observed:

> *"The Bureau combined care for both health and social needs of mothers, children and families. There was strength in combining health and social care, because in many ways they are interrelated. The Bureau served to pull together the various units which played an important role in the health and social care of mothers and children so that better planning and cooperative working relationships could exist."*[66]

THE YEARS 1970 to 1980

The 1970s was a decade in which planning for health was a popular concept. The poverty programs of the 1960s had whetted the appetite of the nation to improve health care. There was a real desire for quantitative measurement of progress toward achieving the goals of improved health for mothers and infants.

- Reductions in the U.S. infant mortality rate continued so that in 1970, the rate was 19.8 per 1,000 live births.[67]

- The discrepancy between white and nonwhite rates remained high: 17.9 for white infants compared to 31.8 for nonwhites.[68]

A report issued by the U.S. Department of Health, Education, and Welfare, *Towards a Comprehensive Health Policy for the 1970s*, noted a long-term trend of improvement in overall health status of the citizens of the United States.[69] Despite these overall gains, the United States ranked behind 12 other industrialized countries in infant mortality. The report enumerated the causes as follows:

- Inadequate geographic distribution of health care.
- Unorganized systems of health care.
- Insufficient availability of financing for preventive (prenatal and screening) services.
- Excessively high costs of medical care.

Attempts were made to address these problems, including the establishment of the National Health Service Corps to provide scholarships for training to individuals agreeing to work in health shortage areas and the passage of the Health Maintenance Organization Act, which provided funding for the development of Health Maintenance Organizations whose primary focus was on disease prevention, health promotion, and managed care.

1970 White House Conference on Children

The most recent White House Conference on Children was convened by President Richard Nixon in 1970. It focused on providing a concrete proposal for a national program of health care for mothers and children and for handicapped children. The final report's recommendations pointed out the ways in which gaps in services could be corrected. Assurance of a decent standard of living for all families was widely supported. Strong reminders were presented that children of minority ethnic affiliation continue to be at significant disadvantage in health and development. The report stated that "improvement in their status had occurred, but their relative position in measurements of health and development is still unchanged."[70]

Scientific developments had provided a better understanding of maternal and fetal physiology which led to the development of prenatal diagnostic and treatment techniques not previously available. These developments were accompanied by a virtual technology explosion in maternal-fetal science as well as in neonatal medicine. The technology made it possible to treat the fetus as well as the pregnant mother. As a result, prenatal care began to incorporate diagnostic tests which assessed the health of the fetus. Although the rate of birth or low birthweight infants did not change much, survival rates of premature infants improved largely due to advances made in the treatment of those infants.

Specialized services for mothers and infants at risk for complications were established which combined technology with highly trained physicians and nurses. These centers were primarily in large population areas, cities with women and infants at high-risk for poor pregnancy outcomes. Because development of these sophisticated services in all areas was financially prohibitive, efforts were made by various groups to develop a regionalization plan which delineated referral patterns of sick newborns and pregnant mothers from community hospitals to sophisticated centers offering the technology and expertise in treating high-risk mothers and infants. In 1976, a report, *Toward Improving the Outcome of Pregnancy* was issued by the March of Dimes which made recommendations for the regional development of maternal and child health services.[71] This report was the culmination of work conducted by a coalition of professional organizations supported by the March of Dimes in their efforts to delineate such a plan.

Regionalization demonstration projects were soon initiated by the Robert Wood Johnson Foundation. In the latter half of the decade, the Improved Pregnancy Outcome program was established by the federal government which provided resources to states to build perinatal regionalization in the community.

At the end of the decade, the United States Surgeon General, Julius Richmond, M.D., published a report entitled *Healthy People*, which presented goals for the health of the people of the United States and set out objectives for attaining those goals.[72] Fifteen priority areas were identified for particular action to improve the health of Americans at five major life stages. For maternal and child health, many goals were proposed·

Specifically for infant mortality, the following was stated: To continue to improve infant health and, by 1990, to reduce infant mortality by at least 35 percent to fewer than 9 infant deaths per 1,000 live births. This was expanded in the subsequent publication, *Objectives for the Nation*.[73]

INFANT MORTALITY IN CURRENT YEARS

Great progress toward reducing infant mortality has been made in the United States during the 1900s. In the early years of this century, infant mortality rates were extremely high.

- A rate of 124 infant deaths per 1,000 live births was reported in 1911, the first year in which the United States Bureau of the Census regarded the registration of infant deaths as "fairly complete."[74]
- International comparisons for early years (1909 and 1910) revealed that, similar to the current situation, the United States was not a leader in the prevention of infant mortality. In fact, during that time 13 countries, including France, England, Ireland, Australia, the Netherlands, and the Scandinavian countries, all ranked better than the United States.[75]

- In the early 1950s the United States was in sixth place among industrialized nations. By 1985, the United States had fallen to 19th place.

- Japan, with a rate of 5.5, is in first place.

Although great progress toward reducing infant mortality has been made during this century, the United States is currently experiencing a virtual stagnation in key indicators of maternal and infant health. The period of most remarkable decline in infant mortality in the United States occurred between 1960 and 1975 when the rate fell by 38 percent. During that time, maternal mortality dropped by 71 percent.[76]

- In recent years, the United States has experienced a slowing rate of decline in infant mortality rates: the average annual rate of decline in the 1981 to 1984 period was 3.7 percent, while the average annual rate of decline during the preceding 10 years was 4.5 percent.[77]

- The difference between the 1984 and 1985 infant mortality rate reflects no real change. The 1984 rate was 10.8; in 1985, it was 10.6. Furthermore, the disparity between black and white rates continues to be wide with the black rate about twice that of the white rate.[78]

LEARNING FROM THE PAST FOR THE FUTURE

Throughout this century, concern has been consistently expressed by health professionals and the general public that the health of the nation's mothers and infants must be safeguarded. For many years, the same strategies to accomplish this mission have been recommended over and over by various professionals and interested citizens. The strategies include:

- **Prenatal Care.** The provision of early, continuous, and comprehensive prenatal care by qualified providers has been recognized as a successful strategy to reduce infant mortality.

- **Effective Federal Coordination of Maternal and Child Health Services.** This is considered essential in assuring nationwide access to affordable, high-quality services.

- **Comprehensive Services.** Comprehensive maternal and child health services that consider the client's health, social, and other needs and provide care for mothers and infants beginning in the prenatal period and extending through early childhood has long been seen as effective in reducing infant mortality.

To effectively plan for the future, we must consider and learn from the past. The themes that were presented in recommendations for reducing infant mortality since the beginning of this century should work in today's environment as well.

REFERENCES

1. U.S. Department of Health and Human Services, National Institutes of Health, "The Panel's Approach to the Study of Prenatal Care," Report of the Expert Panel on Prenatal Care, in press.

2. U.S. Department of Health, Education, and Welfare, Social and Rehabilitation Service, "White House Conference on Dependent Children (1909)," in *The Story of the White House Conferences on Children and Youth*, U.S. Government Printing Office, Washington, D.C., 1967.

3. Ibid.

4. U.S.Department of Health, Education, and Welfare, *Report to the President: White House Conference on Children (1970),* U.S. Government Printing Office, Washington, D.C., 1971.

5. Bremner, R., T. Hareven and R. Mennel, *Children and Youth in America: A Documentary History,* Vol. II, Harvard University Press, Cambridge, 1974.

6. Thompson, Stewart, "Factors that Influence Infant Mortality," *American Journal of Public Health,* Vol. 11, 1921, p. 415-419.

7. Cone, T.E., *History of American Pediatrics*, Little, Brown and Company, Boston, 1979.

8. Newsholme, Arthur, "A Report by the Medical Officer on Infant and Child Mortality," Supplement to the 30th Annual Report of the Local Government Board, London, 1910.

9. Cone, op.cit. No. 7.

10. Starfield, Barbara, "Giant Steps and Baby Steps: Toward Child Health," *American Journal of Public Health*, Vol. 75, No. 6., 1985, p. 599-604.

11. Woodward, William, "The Use of Vital Statistics for the Conservation of Infant Life, Transaction of the American Association for the Study and Prevention of infant Mortality," *American Journal of Public Health*, Vol. 4, 1913, p. 294-296.

12. Bremner, op.cit., No. 5.

13. Schmidt, William, "The Development of Health Services for Mothers and Children in the United States," *American Journal of Public Health*, Vol. 63, No. 5, May 1973, p. 419-427.

14. Cressy, L. W., "The American Association to Prevent Infant Mortality Society Proceedings: Some Measures Urgently Needed for Prevention of Infant Mortality in the United States," *American Journal of Public Health*, Vol. 2, No. 18, 1912, p. 1615.

15. Stevens, A. "The Public Health Nurse in the Extension of Maternity Nursing." *Public Health Nursing*, Vol. 12, 1920, p. 497-501.

16. Williams, J. W., "The Limitations and Possibilities of Prenatal Care," *Journal of the American Medical Association*, Vol. 44, No. 2, p. 95-101.

17. Cone, op.cit., No. 7.

18. Rosen, G., *A History of Public Health*, MD Publications, New York, 1958, p. 349-365.

19. U.S Department of Health, Education, and Welfare, op.cit., No. 2.

20. Bradbury, D. E., *Five Decades of Action for Children: A History of the Children's Bureau*, Children's Bureau, Social Security Administration, Department of Health, Education, and Welfare, U.S. Government Printing Office, Washington, D.C., No. 358, 1962.

21. Children's Bureau, U.S. Department of Labor, *Birth Registration: An Aid in Protecting the Lives and Rights of Children*, U.S. Government Printing Office, Washington, D.C., 1914.

22. Children's Bureau, *Baby-Saving Campaigns: A Preliminary Report on What American Cities are Doing to Prevent Infant Mortality*, Infant Mortality Series No. 1, Bureau Publication No. 3, Children's Bureau, Department of Labor, Government Printing Office, Washington, D.C., 1914.

23. U.S. Department of Health, Education, and Welfare, op.cit., No. 2.

24. Eliot, M. M., "The United States Children's Bureau," *Am. J. Dis. Child.* Vol. 114, p. 135-142, 1960.

25. Ibid.

26. Lesser, A., "The Origin and Development of Maternal and Child Health Programs in the United States," *American Journal of Public Health*, Vol. 75, No. 6, June, 1985, p. 590-598.

27. Ibid.

28. Ibid.

29. Ibid.

30. Schmidt, op.cit., No. 13.

31. Ibid.

32. Children's Bureau, *Prenatal Care*, Department of Labor, U.S. Government Printing Office, Washington, D.C., 1924.

33. Children's Bureau, *Standards of Prenatal Care*, Department of Labor, U.S. Government Printing Office, Washington, D.C., Bureau Publication No. 153. 1925.

34. Bradbury, op.cit., No. 20.

35. Children's Bureau, *Maternal Mortality in 15 States*, Department of Labor, Children's Bureau, Government Printing Office, Washington, D.C., 1934.

36. U.S. Department of Health, Education, and Welfare, op.cit., No. 2.

37. Ibid.

38. Eliot, op.cit, No. 24.

39. Lesser, op.cit., No. 26.

40. Committee on Economic Security, *Report to the President,* U.S. Government Printing Office, Washington, D.C., 1935, p. 37.

41. Lesser, op.cit., No. 26.

42. Ibid.

43. Tandy, E., *Infant and Maternal Mortality Among Negroes,* U.S. Department of Labor, Children's Bureau, U.S. Government Printing Office, Washington, D.C., Bureau Publication No. 243, 1937.

44. Ibid.

45. Pratt, Margaret, "The Demography of Maternal and Child Health," in Wallace, H., E. Gold and A. Oglesby, (eds.), *Maternal and Child Health Practices: Problems, Resources, and Methods of Delivery,* Wiley, New York, 1982.

46. Ibid.

47. U.S. Department of Health, Education, and Welfare, op.cit, No. 2.

48. Ibid.

49. Pratt, op.cit., No. 45.

50. Ibid.

51. Bradbury, op.cit., No. 20.

52. Ibid.

53. U.S. Department of Health and Human Services, op.cit.,
No. 2.

54. Ibid.

55. Starfield, op.cit., No. 10.

56. Pratt, op.cit., No. 45.

57. Starfield, op.cit., No. 10.

58. U.S. Department of Health, Education, and Welfare, op.cit, No. 2.

59. Ibid.

60. Ibid.

61. Lesser, A. J. "The Federal Government in Child Health Care," *Pediatric Clinics of North America,* Vol. 16, No. 4,
November 1969.

62. Ibid.

63. Eliot, op.cit., No 24.

64. Lesser, op.cit., No. 61.

65. Pratt, op.cit., No. 45.

66. Wallace, Margaret, quoted in "Maternal-Child Health Before and After Title V," Public Health Currents, Ross Laboratories, Dayton, Ohio.

67. Pratt, op.cit., No. 45.

68. Ibid.

69. U.S. Department of Health, Education, and Welfare, *Towards a Comprehensive Health Policy for the 1970s,* U.S. Government Printing Office, Washington, D.C., 1971.

70. Lesser, op.cit., No. 26.

71. The National Foundation, March of Dimes, "Toward Improving the Outcome of Pregnancy, *Recommendations for the Regional Development of Maternal and Perinatal Health Services,* The National Foundation, White Plains, New York, 1976.

72. U.S. Department of Health and Human Services, *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention,* U.S. Government Printing Office, Washington, D.C., 1979.

73. U.S. Department of Health and Human Services, Public Health Service, *Promoting Health/Preventing Disease: Objectives for the Nation,* U.S. Government Printing Office, Washington, D.C., 1980.

74. Bremner, op.cit., No. 5.

75. Ibid.

76. Miller, C, "Infant Mortality in the U.S.," *Scientific American,* Vol. 253, No. 1, 1985, p. 31-37.

77. Children's Defense Fund, *The Health of America's Children,* Washington, D.C., 1987.

78. U.S. Department of Health and Human Services, National Center for Health Statistics, Final Mortality Data for 1985.

Selected Major Reports with Recommendations to Reduce Infant Mortality Rate: 1900-1988

CATEGORIES OF RECOMMENDATIONS

Report	Improved Federal Coordination of Maternal/Child Health Programs	Complete Data Collection, Vital Statistics	Improved Systems of Perinatal Care	Improved Quality & Distribution of Health Care Providers	Improved & Expanded Infant Care Services	Improved Nutrition Services	Improved Social Support Systems	Improved Standards of Maternal & Infant Care	Prenatal Care: Services Expanded & Improved	Planning for Pregnancy: Environment, Education, Timing
1909 White House Conference on Children and Youth	•	•	•	•	•		•	•	•	•
1914 Baby Saving Campaigns, Cities Prevent Infant Mortality	•	•	•	•	•	•	•	•	•	•
1914 Birth Registration: An Aid in Protecting the Lives of Children	•	•								
1919 Maternity Benefit Systems in Foreign Countries	•	•	•	•	•	•	•	•	•	•
1919 White House Conference on Child Welfare Standards	•		•	•	•	•	•	•	•	•
1925 Standards of Prenatal Care		•				•	•	•	•	•
1926 Proceedings of the Conference of Directors of the Maternity & Infancy Act	•	•	•	•	•	•	•	•	•	•
1930 White House Conference on Child Health and Protection	•	•	•	•	•	•	•	•	•	•
1937 Infant and Maternal Mortality Among Negroes	•	•	•	•	•	•	•	•	•	•
1940 White House Conference on Children in a Democracy	•			•	•					
1945 Services for Unmarried Mothers and their Children	•			•	•	•	•		•	
1950 Midcentury White House Conference on Children & Youth			•	•						
1960 Golden Anniversary of the White House Conferences on Children & Youth	•	•	•	•	•	•	•	•	•	•
1966 Maternal and Child Health Care Programs	•	•	•	•	•	•	•	•	•	•
1969 Key Issues in Infant Mortality	•	•	•	•	•	•	•	•	•	•
1970 The Prevention of Perinatal Mortality and Morbidity	•	•	•	•	•	•	•	•	•	•
1973 An Analysis of Maternal Risk & Health Care	•	•	•	•	•	•	•	•	•	•
1976 Toward Improving the Outcome of Pregnancy	•		•	•					•	
1980 Promoting Health Preventing Disease:Objectives for the Nation	•	•	•	•	•	•	•	•	•	•
1981 Better Health for Our Children: The Report of the Select Panel	•	•	•	•	•	•	•	•	•	•
1985 Preventing Low Birthweight	•		•	•	•	•	•	•	•	•
1985 Southern Regional Task Force on Infant Mortality	•	•	•	•	•	•	•	•	•	•
1987 Financing Maternity Care in the U.S.	•		•	•	•	•			•	•
1988 Healthy Children: Investing in the Future	•		•		•			•	•	

ISSUE BRIEFS

LOW BIRTHWEIGHT

LOW BIRTHWEIGHT

A Summary

- Low birthweight refers to infants born weighing less than 5-1/2 pounds. This may result from a baby not growing adequately during the pregnancy or a baby being born too soon. The smaller the baby, the poorer the chances for survival.

- The low birthweight rate for the United States in 1985 was 6.8 percent, or 253,554 babies. In 1985, that was 1 in every 15 infants: 1 in 18 for whites, 1 in 9 for Hispanics, and 1 in 8 for blacks. The rate for black infants is twice that for whites.

- A baby born too small or too soon has a greater likelihood of needing very expensive, high technology care and of being hospitalized repeatedly. The costs to the U.S. health care system can be as much as $30,000 per low birthweight infant.

- Not only are the direct health care costs for low birthweight high, but so are the costs to society as a result of lost productivity. If we could reduce by half the number of disabled low birthweight infants born, the present value of wages that could have been earned over the children's lifetimes would be $0.9 10 $1.9 billion.

- Low birthweight is a major factor in infant mortality; babies born weighing less than 5-1/2 pounds are 40 times more likely to die in the first month of life than are babies who are normal weight. The risk of mortality increases with decreasing birthweight; babies born very low birthweight are 200 times more likely to die.

- Low birthweight survivors are twice as likely to suffer one or more handicaps, such as cerebral palsy, chronic lung problems, epilepsy, delayed speech, blindness, deafness, or mental retardation.

- One in seven infants born to teenage mothers is likely to be born low birthweight--a baby born to a teenager is also more than twice as likely to die than a baby born to a woman in her twenties.

- Early, continuous, and high-quality prenatal care significantly reduces both maternal and infant mortality and the risk of low birthweight. In 1985, 24 percent of all mothers did not receive prenatal care in the critical first 3 months of pregnancy.

- Despite many unanswered research questions concerning the causes of low birthweight, policymakers have enough information to act more vigorously to reduce the incidence of low birthweight and to improve the health of this nation's infants and children.

- Useful approaches include placing emphasis on (1) reducing risks before pregnancy, (2) increasing access to early and continuous prenatal care, (3) enriching prenatal care to meet the varying needs of both high- and low-risk women, and (4) developing a long-term, national, political commitment to reducing the incidence of low birthweight and infant mortality in general.

LOW BIRTHWEIGHT

The United States has been paying a high cost in dollars and, more importantly, in lost human potential for babies born too soon or too small. The United States has fallen to a tie for last place among 20 industrialized nations in preventing babies from dying in the first year of life. Too many American infants either die before their first birthday or suffer from mental or physical disabilities that can last a lifetime.

In the United States, 10 percent to 20 percent of our children have at least one chronic disease or handicapping condition, and every year more than 40,000 infants die before their first birthday. Many of these infant deaths and disabilities are a result of low birthweight--a term that refers to babies born weighing less than 5-1/2 pounds--a condition that, in many cases, could be prevented.

Despite an incomplete answer as to what exactly causes low birthweight, policymakers, encouraged by the public's will to do so, have enough information to intervene more vigorously to improve the health of this nation's infants and children. Useful approaches include placing an emphasis on reducing risks before pregnancy, increasing access to early and continuous prenatal care, enriching and targeting prenatal services to meet the varying needs of both high- and low-risk women, and developing a long-term, national, political commitment to reducing the incidence of low birthweight and infant mortality and morbidity in general.

THE PROBLEM

In 1985, the low birthweight rate was 6.8 percent, or 253,554 babies. Each low birthweight infant stands a greater chance of dying or being severely handicapped. Low birthweight is usually related to either inadequate fetal growth during pregnancy, (referred to as intrauterine growth retardation), an early birth (referred to as premature, born before 9 months), or both.

Being born too small or too soon has serious consequences for infants, their families, and society as a whole. Babies born low birthweight are 40 times more likely to die in the first month of life (neonatal mortality). If they live to celebrate their first birthday, they are twice as likely to suffer one or more handicapping conditions, such as cerebral palsy, chronic lung problems, epilepsy, delayed speech, blindness, deafness, or mental retardation. These infants are also more likely to need very expensive, high-tech medical care at birth and throughout their first year and to be repeatedly hospitalized. The problem of low birthweight has unfortunately not diminished, even though infant mortality has. Between 1965 and 1985, this country made great strides by reducing the number of infant deaths from 24.7 to 10.6 per 1,000 live births. This positive trend has not been repeated with low birthweight. After declining from 1950 to 1979, the low birthweight rate remained virtually unchanged from 1980 to 1984. It then increased about 1 percent between 1984 and 1985.

FACTORS ASSOCIATED WITH LOW BIRTHWEIGHT

Two conditions affect birthweight: intrauterine growth retardation (a baby who does not grow enough) and prematurity (a baby born before 9 months gestation). Understanding the specific cause is complicated because often these conditions coexist: infants are born before 9 months gestation *and* have not grown appropriately for their length of gestation. The exact physiologic reasons for reduced growth are not known nor are the exact physiologic and biochemical events that initiate premature labor.

However, such conditions as chronic high blood pressure; kidney disease; sickle cell anemia; multiple pregnancies (twins or triplets); a fetal chromosomal disorder; a fetal infection, such as rubella or syphilis; or any radiation injury may result in growth retardation.

While the specific medical causes remain unknown, a great deal *is* known about the types of women at risk to deliver a low birthweight infant and what preventive measures can be taken to ensure the best possible outcome.

Generally, the risk factors include:

- demographic characteristics, such as the mother's age, race, marital and educational status, income, and poverty level;

- medical conditions that can be identified before pregnancy, such as diabetes, a previous poor pregnancy outcome, and the number of previous pregnancies;
- behavioral and environmental factors, such as smoking, drinking, drug use, poor nutrition, and exposure to toxic substances;
- health care risks, such as inadequate prenatal care; and
- other variables, such as stress, uterine irritability, and a host of infections.

This list of factors can be used to help identify risk groups among pregnant women and to target interventions. Some risk factors cannot be altered or reduced, such as age or race. However, others, such as poor weight gain, anemia, poor nutrition, alcohol or other substance abuse, and particularly smoking, can be altered or reduced if recognized and if behavior is changed.

THE COSTS OF LOW BIRTHWEIGHT

The decrease in infant deaths over the years has been due primarily to the advances in medical technology and the ability to keep babies alive during the first critical month of life. This intensive care is extremely expensive. The total cost of neonatal intensive care exceeds $2.5 billion per year. The cost to "graduate" a sick infant from this kind of intensive care ranges from $20,000 to $100,000 *per infant*. The Office of Technology Assessment estimated that the U.S. health care system can save as much as $30,000 in health care costs for every low birthweight birth averted by earlier or more frequent prenatal care. The overall lifetime costs for special care for handicapping conditions many of these infants suffer can soar to $400,000 per child.

Not only are the direct health care costs for low birthweight high, but so are the costs to society as a result of lost productivity. If we could reduce by half the number of disabled low birthweight infants born, the present value of wages that could have been earned over the children's lifetimes would be $0.9 to $1.9 billion.

Many of these infants and their families are not covered by any form of health insurance. In 1985, more than 11 million children under 18, 1 in every 6, were completely uninsured. This figure represents a 16 percent increase in just 3 years. To pay for their care, hospitals throughout the country traditionally have simply shifted the costs of those who could not afford to pay to paying patients. Forty-three percent of indigent admissions to hospitals are obstetric, gynecologic, newborn, or pediatric patients. In 1985, 27 percent of maternity and newborn costs represented $7.4 billion in unpaid hospital bills.

The cost of caring for low birthweight infants is an example of how the costs for a few can drastically affect the care for all. Three percent of all newborns use nearly 50 percent of all health care dollars devoted to the care of *all* newborns, healthy or sick.

PREVENTION STRATEGIES

Numerous studies have been done on the subject of low birthweight, most notably by the Institute of Medicine. These studies offer several promising strategies for reducing the occurrence of low birthweight. They include:

- Planning for pregnancy--healthy pregnancies begin before conception. Therefore, the importance of family planning, pre-pregnancy risk identification, counseling, and risk reduction are essential to reducing low birthweight.

- Prenatal care--the evidence to support the value of prenatal care *early in pregnancy* in reducing low birthweight is strong enough to support a national commitment to ensuring that all pregnant women receive prenatal care.

- Ensuring access to services--many of the women who receive inadequate prenatal care are those most at risk for a poor pregnancy outcome. Barriers to obtaining adequate services have to be removed.

- Selected interventions--such as smoking and other substance abuse interventions, nutritional intervention programs such as the Special Supplemental Food Program for Women, Infants, and Children (WIC), and other services intended to be supportive of the pregnant mother--are components that should be included in any effort to reduce low birthweight. Many of these interventions to reduce risk must be brought to bear as early in pregnancy as possible.

- Public awareness--the general public and this nation's political leaders need to be made aware of the problems of low birthweight and infant mortality and spurred to action.

CONCLUSION

The prevention of low birthweight would contribute significantly to the reduction of infant mortality and improve child health in general in the United States. There are unanswered questions about precisely what causes low birthweight, and additional research is needed. Policymakers, however, can act now to help solve this problem. Many preventive strategies could be implemented to reduce the numbers of preventable deaths and disabilities.

Useful approaches include placing greater emphasis on identifying risk factors and intervening to reduce those risks to the pregnancy, increasing the accessibility and financial availability of prenatal care and other preventive health care services, enhancing the content of prenatal care so that it comprehensively meets the individual needs of a given pregnancy, and developing a public awareness campaign that informs the general public about the risk factors involved in low birthweight and what pregnant women and their families can do to avoid or ameliorate their risks. These efforts could be enriched by additional ongoing research.

Preventive efforts prior to the birth of a child to prevent a poor pregnancy outcome will inevitably be less expensive than the high technology costs of caring for a baby born too soon or too small.

Progress in the direction recommended here will require the recognition of low birthweight and infant mortality as important national problems. The federal and state governments, the private sector, media, civic organizations, the religious community, schools, and others all have a role to play.

REFERENCES

The Alan Guttmacher Institute, *Blessed Events and the Bottom Line: Financing Maternity Care in the United States*, New York, 1987.

American Nurses' Association, *Access to Prenatal Care: Key to Preventing Low Birthweight*, Kansas City, Missouri, 1987.

Food Research and Action Center, *Poor Infants, Poor Chances: A Longitudinal Study of Progress Toward Reducing Low Birthweight and Infant Mortality in the United States and its Largest Cities, 1979-1984*, Washington, D.C., 1987.

Institute of Medicine, *Preventing Low Birthweight*, National Academy Press, Washington, D.C., 1985.

Miller, A.C., *Maternal Health and Infant Survival*, National Center for Clinical Infant Programs, Washington, D.C., 1987.

U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future*, OTA-H-345, U.S. Government Printing Office, Washington, D.C., February 1987.

U.S. Department of Health and Human Services, Public Health Service, *Promoting Health/Preventing Disease: Objectives for the Nation*, DHHS Pub, No., (OM) 81-0007, U.S. Government Printing Office, Washington, D.C., 1980.

U.S. Department of Health and Human Services, *Report of the Secretary's Task Force on Black and Minority Health, Vol. VI: Infant Mortality and Low Birthweight*, Washington, D.C., 1983.

POSTNEONATAL MORTALITY

POSTNEONATAL MORTALITY

A Summary

- Postneonatal mortality--infant deaths that occur between the 28th day of life and the end of the first year--accounts for 30 percent of all infant deaths.

- Postneonatal mortality often reflects living conditions, quality of care for children, and medical care for treatable or controllable conditions, such as infection and accidents.

- There has been no significant reduction in postneonatal mortality in recent years. The percentage of deaths occurring in the postneonatal period (percent of total deaths) has actually increased. This implies that many infant deaths are not being prevented but rather delayed.

- In 1985, the three main causes of postneonatal death were Sudden Infant Death Syndrome (SIDS), 4,933 deaths; congenital anomalies, 2,192 deaths; accidents (including homicides), 963 deaths; and 3,881 deaths classified as "other" (no recorded cause on the death certificate).

- The groups most recognized to be "at risk" for postneonatal mortality are generally the same infants who were at risk at birth, such as low birthweight infants. Postneonatal deaths do occur (70 percent to 75 percent) among normal-weight infants. Blacks, Hispanics, American Indians, infants born to young unmarried mothers, and infants born into poverty are at increased risk for postneonatal mortality.

- Research dollars and interventions have tended to be targeted at the neonatal (first 28 days of life) population rather than postneonatal. Interventions for saving infants during the first month of life are highly technological. The solutions to postneonatal mortality are more complex, interwoven into much larger societal issues such as poverty, and dependent on change other than in the medical arena.

- Each community is encouraged to review its death certificates to determine the main causes of infant death in its own area. The causes of death are different and many are often preventable. If a substantial proportion of deaths are a result of fire or falls, the solutions are very different than if they are from congenital birth defects.

- Policies and strategies to reduce infant mortality cannot ignore the increased role environmental and social issues are playing in the ability of young children not only to survive, but to live a healthy life.

POSTNEONATAL MORTALITY

The **infant mortality** rate (the number of deaths to infants under 1 year of age per 1,000 live births) is generally regarded as a "quality of life" indicator for the health and welfare of a population. Disparities in mortality rates among population groups reflect differences in access to food, shelter, adequate health care services, and education. Infant deaths are classified according to one of two time periods: neonatal or postneonatal.

Neonatal mortality refers to infant deaths that occur in the first 28 days of life and account for 70 percent of all infant deaths. Neonatal mortality tends to be closely associated with low birthweight and with influences occurring prenatally, during birth, and in the newborn period, such as poor maternal nutrition, poor health habits, lack of quality obstetric and neonatal health services, and congenital birth defects.

Postneonatal mortality refers to deaths that occur after the 28th day and before the end of the first year and account for the remaining 30 percent of all infant deaths. Postneonatal mortality tends to be associated with the environmental circumstances of the infant, particularly those linked to poverty, such as inadequate nutrition, poor sanitation, unsafe housing, and lack of access to preventive health care services. Postneonatal mortality is perhaps the clearest reflection of the disparities among population groups as it is often a reflection of the health consequences of low socioeconomic status.

REASONS FOR CONCERN

- Postneonatal mortality rates have not been reduced in the United States during the last decade; in fact, postneonatal mortality rates increased between 1975 and 1976, 1977 and 1978, and 1982 and 1983.

- Research suggests that the intensive medical efforts in the neonatal period may merely delay rather than prevent some infant deaths.

- The racial disparities for postneonatal mortality have not changed dramatically since the early 1900s. Black infants are twice as likely to die as are white infants; Hispanic and American Indians are also at significantly greater risk.

- Many postneonatal deaths could be prevented: 963 infants died in 1985 from accidents and homicides.

- Unlike neonatal mortality where the causes are relatively well understood, the array of factors that affect postneonatal mortality are less well understood and more difficult to change.

THE LEADING CAUSES OF DEATH

Generally, the causes of death in the postneonatal period tend to be associated with the environmental circumstances of the infant, particularly those linked to poverty, such as inadequate nutrition, poor sanitation, unsafe housing, and lack of access to health services. Circumstances that carry over from the neonatal period, such as being born premature, at low birthweight, to a young unmarried mother, and into a family whose income is below the poverty line, also influence postneonatal mortality.

In 1985, the three main causes of death within the postneonatal period were:

- SIDS, 4,933 deaths;
- Congenital anomalies, 2,192 deaths; and
- Accidents (including homicides), 963 deaths.

For a complete list of the leading causes of death, see table I.

THOSE AT RISK FOR POSTNEONATAL MORTALITY

The data on postneonatal mortality are sparse. Close to half of all the postneonatal deaths are recorded as "cause unknown" on the death certificate, and the linking of birth and death certificates for the postneonatal period was not done on a national scale prior to 1987. Research defining risk in the postneonatal period is, therefore, an evolving concept. There is a generally agreed upon series of factors that assist in determining an infant's risk. Some of these factors are associated with the mother's health and lifestyle, while others concern the infant's health status in the first month of life and thereafter.

Parental and Psychosocial Factors

An infant may be at increased risk for postneonatal mortality or illness if its mother had little or no prenatal care, is young and/or unmarried, abuses drugs or alcohol, is handicapped, is mentally retarded, is suffering from AIDS, has psychological disorders, has no permanent home, is poor, or has inadequate parenting skills.

Newborn Health Factors

An infant may be at increased risk if he or she suffered complications in the neonatal period, such as low birthweight, especially very low birthweight; respiratory distress; birth asphyxia (decreased oxygen supply during the delivery process); seizures; central nervous system abnormalities; jaundice; or any suspected impairment, such as hearing or vision loss and birth defects.

Other Factors

The list of "other" factors associated with the infant, while a long one, includes no regular source of professional health care for the infant; abuse or neglect; inadequate nutrition or hygiene, a poor response to parents; any growth or development deficiencies; newly diagnosed conditions, such as mental retardation; other mental disorders; AIDS; lead poisoning; and others.

The concept of risk in the postneonatal period includes both health and social factors. A better understanding of postneonatal risk factors is a *must* if preventive health care providers are to be able to assess and intervene appropriately. Early assessment leads to preventive interventions. Late or no assessment can result in crisis management or death.

ADDITIONAL CONCERNS

Other issues are important when considering postneonatal mortality:

- There has been no significant reduction in postneonatal mortality in recent years. The percentage of deaths occurring in the postneonatal period (percent of total deaths) has actually increased. This implies that many infant deaths are not being prevented but rather delayed.
- Solid data concerning postneonatal risk factors are severely lacking. Certain predefined categories of infants, such as those born low birthweight, are at increased risk, but very little is known about the causes and factors associated with normal weight and other seemingly "normal" infants.
- The causes and risk factors associated with postneonatal mortality are many and are subsets of much larger social and environmental problems; a comprehensive national strategy to reduce infant mortality will need to address both the medical and social issues.
- The issue of postneonatal mortality, however, cannot be categorized as an entirely environmental or social issue. Many of the issues are indeed global, such as poverty. Health care intervention, however, should serve as a checkpoint, an assessment of the health and well-being of the family and child. Ideally, this assessment would trigger interventions that could prevent death or any further deterioration in health.
- Research dollars and interventions have been predominantly targeted at the neonatal population rather than prenatal or postneonatal. Interventions for saving babies in their first month of life are more technical, medical, and, therefore, tangible. Research and action must also be targeted to the postneonatal population as well.
- The concept of risk for the postneonatal period is best viewed as a continuum, beginning with the mother during pregnancy and continuing throughout the early months of the child's life. Social, environmental, and medical interventions must be targeted at various points along this continuum.
- Each community could improve infant health and survival by reviewing its death certificates to determine the main causes of infant death. The causes of postneonatal death vary and many, such as accidental injuries, could be prevented. If a substantial proportion of deaths are a result of fire or falls, the solutions are very different than if they are from congenital birth defects.

Table 1
Postneonatal Mortality by Leading Causes of Death, 1985

Cause	Number	Rate*	Percent
All causes of postneonatal death	13,851	368.3	100.0
Sudden Infant Death Syndrome	4,933	131.2	35.6
Other	3,881	103.2	28.0
Congenital anomalies	2,192	58.3	15.8
Accidents and adverse effects	805	21.4	5.8
Pneumonia and influenza	554	14.7	4.0
Septicemia	303	8.1	2.2
Respiratory distress syndrome	271	7.2	2.0
Meningitis	207	5.5	1.5
Homicide	158	4.2	1.1
Bronchitis and bronchiolitis	100	2.7	0.7
Cancer	85	2.3	0.6
Viral diseases	82	2.2	0.6
Gastritis,duodenitis,noninfective enteritis or colitis	81	2.2	0.6
Intrauterine hypoxia and birth asphyxia	74	2.0	0.5
Meningococcal infection	68	1.8	0.5
Diseases of the blood and blood-forming organs	57	1.5	0.4

* *Deaths per 100,000 live births*

SOURCE: National Center For Health Statistics.

- Policies and strategies to reduce infant mortality cannot ignore the issue of postneonatal mortality and the increased role environmental, social, and medical access issues are playing in the ability of young children to survive.

CAUSES OF DEATH

SIDS: 4,933 deaths in 1985

SIDS is the leading cause of death for infants older than one month and accounts for close to 36 percent of all postneonatal deaths. SIDS is the sudden, unexpected and unexplained death of apparently healthy infants between the ages of 1 month and 1 year.

At this time, SIDS cannot be accurately predicted or prevented as its cause(s) remains unknown. What is known is that SIDS occurs more often among infants born to women younger than 20 years of age, to mothers who received no prenatal care, and to mothers of low socioeconomic status. SIDS occurs more frequently in the late fall and winter, among the second born of twins, and in the early postneonatal period. The rate of SIDS among black infants is two to three times higher than among white infants.

In the majority of cases, the SIDS infant was reported to be well nourished, well developed, and in good health before death. These infants simply stop breathing, often in their sleep. Evidence of atypical sleep patterns and apnea (periods when the infant stops breathing) are associated with an increased risk of SIDS. Home breathing monitors seem to be an effective yet expensive preventive warning device, but they do not cure the apnea.

The proportion of infant mortality due to SIDS has increased over the years. There is concern that SIDS has recently become a catch-all category, with deaths incorrectly being classified as SIDS. Research efforts must continue to refine our ability to identify those infants at risk and to effectively prevent this condition.

CONGENITAL BIRTH DEFECTS: 2,192 deaths in 1985

Birth defects are the second leading cause of postneonatal mortality, close to 16 percent of all postneonatal deaths. Birth defects become the predominant cause of infant mortality as medical care and overall health status improve and infant mortality rates decline in developed countries. In the United States, about one sixth of all infant deaths are related to birth defects, including congenital anomalies, mental retardation, and genetic disorders. Congenital anomalies are deviations from what is normal, such as organs that are not correctly formed. Unfortunately, the deformity is often inoperable.

Down's syndrome, a genetic chromosomal defect resulting in mental retardation, is perhaps the most common birth defect; it affects over 5,000 newborns a year. About 25 percent of all congenital defects are thought to be genetic in nature, more than 10 percent are due to environmental causes and the remaining 65 percent are of unknown origin.

Genetic services, including counseling based on family history, testing for carrier status, and prenatal diagnosis via amniocentesis (or other genetic techniques, such as chorionic villi sampling and alpha feto protein), are the best available strategies to detect an infant at risk for a genetic disorder. The prenatal visit, or preferably a preconceptional visit, is the opportune time for such screening and determination of risk and possible interventions. Current genetic knowledge, however, does not allow correction of each disorder once detected.

Environmental factors that may have an adverse effect on the fetus include radiation, drugs, and alcohol. These teratogenic factors have their greatest negative effect during the early weeks of pregnancy and fetal development, often before a woman realizes she is pregnant.

ACCIDENTS (including homicides): 963 deaths in 1985

Accidents, injuries, and homicides account for 7 percent of postneonatal mortality for both black and white infants. Black infants are slightly more than twice as likely to die from injuries as white infants. The leading infant injuries are suffocation, fires, motor vehicle accidents, and homicides (many are hand gun related.)

Preventable injuries kill more American children under the age of 13 than all childhood diseases combined. One in every four infants and young children are expected to suffer a preventable injury serious enough to require medical attention this year. In 1987, 8,000 children under 13 years of age were killed and another 50,000 were permanently disabled as a result of injuries and accidents. Between 80 percent to 90 percent of all these accidents are preventable.

OTHER CAUSES: 3,881 deaths in 1985

In terms of numbers of deaths, the second leading classification of death in the postneonatal period is "other causes." The fact that the cause of death for 28 percent of all postneonatal deaths is unknown mandates better recording on death certificates. Communities and the nation need to know what their infants are dying of in order to intervene on behalf of both their health and their life. A nation cannot devise and implement strategies to save infants throughout the first year of life if the reasons for these deaths are unknown.

CONCLUSION

Any effort to reduce infant mortality in this country must include preventive strategies targeted at the causes of postneonatal deaths in any given community, city, or state. A reduction in postneonatal mortality rates will require efforts that go beyond the medical arena. Many of the factors used to identify potentially "at-risk" infants and children are environmental, behavioral, and societal conditions, such as poor use of preventive health care services, poverty, and an unsafe living environment. These conditions often serve to exacerbate preexisting problems such as low birthweight, teen parentage, and the presence of any infant disabilities.

Doing what we know works, such as discharge plans for all infants leaving the hospital (plans that link infants to preventive health services), education concerning the basics of infant feeding and care, and some network of support services to assist the new family in the transition should be encouraged in every community, in each state, and the nation. Such a preventive, comprehensive, and easily accessible system does not as yet exist for many families.

REFERENCES

National Center for Clinical Infant Programs, *Warning Signals: Basic Criteria for Tracking at Risk Infants and Toddlers*, Washington, D.C., 1986.

Sachs, Susan Bakewell, *Postneonatal Risk: The Concept, Its Description, and Its Implications,* University of Pennsylvania, 1988.

U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future*, OTA-H-345, U.S. Government Printing Office, Washington, D.C., February 1988.

U.S. Department of Health and Human Services, Public Health Service, *Promoting Health/Preventing Disease: Objectives for the Nation,* DHHS Pub. No. (OM) 81-0007, U.S. Government Printing Office, Washington, D.C., 1980.

U.S. Department of Health and Human Services, Public Health Service, *Better Health for Our Children: A National Strategy,* the report of the Select Panel for the Promotion of Child Health, DHHS Pub. No. (PHS) 79-55071, U.S. Government Printing Office, 1981.

PRENATAL CARE

PRENATAL CARE

A Summary

- Prenatal care is defined as pregnancy-related health care services provided between conception and delivery.

- According to the American College of Obstetricians and Gynecologists (ACOG) standard, "every woman should have a comprehensive program of prenatal care beginning as early in the first three months of pregnancy as possible."

- Prenatal care, as early as 1914, was recognized as playing an important role in reducing both maternal and infant mortality by preventing poor pregnancy outcomes and low birthweight.

- Early, continuous, and comprehensive prenatal care is especially important to those women considered to be at increased medical or social risk for delivering a low birthweight infant, including minority, adolescent, and low-income women.

- Babies born to women who receive no prenatal care are three times more likely to be low birthweight than babies born to women who receive early care. About 80 percent of the women at risk for having a low birthweight baby can be identified in the first prenatal visit and interventions to reduce the risk can be made.

- Prenatal care is cost-effective. The Institute of Medicine found that for every dollar spent on prenatal care, $3.38 is saved in the cost of care for a low birthweight infant. In other studies, cost-benefit estimates range from $2 to $10 saved for every dollar spent on prenatal care.

- Too many women, however, do not get prenatal care--34 percent of pregnant women, some 1.3 million a year--are getting what is generally considered insufficient prenatal care. According to a recent study, 662,000 women in 1986 did not begin care until the second trimester; and 207,000 either received no care or did not begin care until the third trimester of pregnancy.

- Nationally, we have made little progress in improving prenatal care statistics. The percentage of women obtaining prenatal care in the first trimester remained essentially the same from 1980 to 1985, 76.3 percent versus 76.2 percent.

- Many women do not have the financial resources to pay for care. According to a recent study, of all women aged 15 to 44, 17 percent had no health insurance in 1986. Young, black, and Hispanic women were more often without insurance. Numerous studies show that women without the financial means to pay for care often go without.

PRENATAL CARE

Prenatal care is defined as pregnancy-related health care services provided between conception and delivery. According to the American Academy of Pediatrics and ACOG, prenatal care involves

- monitoring the health status of pregnant women;
- providing patient information to foster optimal health, good dietary habits, and proper hygiene; and
- providing appropriate psychological and social support.

The Expert Panel on Prenatal Care, convened by the U.S. Department of Health and Human Services, further defines it as "the composite of health promotion activities and watchful concern/protection carried out by the pregnant woman, her family and friends, and her health professionals from the time of conception until labor begins, for the purpose of maintaining or improving the health of the pregnant woman and providing a healthy intrauterine environment for the fetus. Prenatal care includes specific prenatal visits, prenatal contacts and prenatal education, and support deemed essential for good health and optimum outcomes of pregnancy for the woman, the infant, and the family."

According to the ACOG standard, "every woman should have a comprehensive program of prenatal care beginning as early in the first three months of pregnancy as possible." A woman with an uncomplicated pregnancy should be seen every 4 weeks for the first 28 weeks of pregnancy, every 2 to 3 weeks for the next 8 weeks, and weekly thereafter until delivery. The number of visits increases for a problem pregnancy. Because the nature of the complication varies, ACOG does not specify a number of visits recommended for complicated pregnancies.

Generally, the health status of a woman is monitored through a series of prenatal care visits to an obstetrician or other health care provider, such as a family practitioner or certified nurse midwife. These visits provide an opportunity to develop a medical, environmental, and social history; perform medical exams and laboratory tests; establish an expected delivery date; assess any risks to the pregnancy; and determine the need, if any, for appropriate interventions, such as smoking cessation.

THE IMPORTANCE OF PRENATAL CARE

As early as 1914, prenatal care was recognized as playing an important role in reducing both maternal and infant mortality by preventing poor pregnancy outcomes and low birthweight.

There are two broad categories of reasons why prenatal care is important: access to prenatal care better ensures the health of pregnant women and their infants, and prenatal care is cost-effective.

Prenatal Care Improves the Health of Mothers and Infants

According to a recent analysis by the Department of Health and Human Services, nearly 80 percent of all women at risk for having a low birthweight baby can be identified in the first prenatal visit, and interventions can be subsequently employed to improve the health of the mother and infant. Infants born to women who do *not* receive sufficient care are about twice as likely to be a low birthweight infant--an infant who is 40 times more likely to die in the first month of life than normal-weight infants. These women are also more likely to deliver prematurely and gain too little weight during pregnancy.

Infant mortality rates in 1985 varied depending on the amount and timing of prenatal care: 9.7 deaths per 1,000 live births among newborns whose mothers began care in the first trimester, 12.5 per 1,000 for those who began care later in pregnancy, and 48.7 per 1,000 in cases where the mother obtained no care at all.

Clearly, prenatal care is not the only factor. Poverty, unsanitary living conditions, unintended pregnancies, and poor nutrition also play a role. The prenatal visit, however, offers the opportunity to assess these other risks, implement interventions, and otherwise assist the woman throughout pregnancy.

Prenatal Care Is Cost-Effective

The average cost for professional services associated with prenatal care, excluding the labor and delivery charges, can run as low as $400. Prenatal care has been determined a cost-effective program compared to the costs incurred for the often preventable condition of low birthweight among newborns. According to the Office of Technology Assessment, the U.S. health care system saves between $14,000 and $30,000 in first-year hospital and long-term health care costs for every low birthweight birth averted by earlier or more frequent prenatal care. Additionally, the costs for lifetime care for an infant born with physical or mental disabilities can be hundreds of thousands of dollars. The Institute of Medicine estimated that in 1985, for every $1.00 spent on prenatal care, $3.38 could be saved in the costs of caring for low birthweight infants. The American Academy of Pediatrics reported that the cost-benefit estimates ranged from $2 to $10 saved for every dollar spent on prenatal care.

ACCESS TO ADEQUATE PRENATAL CARE

The services associated with pregnancy are known to be essential, but are not available and accessible to all who need them. Thirty-four percent of pregnant women--some 1.3 million a year--are getting what is generally considered insufficient prenatal care.

According to a 1987 study by the Alan Guttmacher Institute, 662,000 women in 1986 did not begin care until the second trimester and 207,000 either received no care or did not begin care until the third trimester of pregnancy. The highest rate of insufficient prenatal care occurs among unmarried women (58 percent), followed by the least educated (56 percent), blacks (51 percent), and Hispanics (47 percent). Poor women and women without insurance are also less likely to get adequate care.

PROGRESS IN WOMEN RECEIVING ADEQUATE PRENATAL CARE

The Surgeon General's report on Health Promotion and Disease Prevention in 1979 set out numerous national health objectives for the nation for the year 1990. The objectives related to prenatal care will not be met by 1990. The percentage of women obtaining prenatal care in the first trimester remained essentially the same from 1980 to 1985--76.3 percent versus 76.2 percent. Internationally, the United States ranks behind at least 19 other industrialized nations in infant mortality. As for prenatal care, there are numerous countries such as Japan, Sweden, Denmark, and France where between 95 percent to 99 percent of all women receive early and continuous prenatal care.

BARRIERS TO RECEIVING ADEQUATE PRENATAL CARE

The barriers to accessing prenatal care are formidable in this country. **Financial barriers** are often cited as most important. Maternity care, like general health care in the United States, is paid for by a mix of private health insurance, public financing systems, and out-of-pocket payments by the patient and her family. Financial coverage, however, is by no means complete. The most vulnerable populations left uncovered are women, infants, and children. According to the Alan Guttmacher Institute, of all women aged 15-44 in 1986, 17 percent had no health insurance. Young, black, and Hispanic women were more often without insurance. Numerous studies show that women without the financial means to pay for care often go without it. According to the same Alan Guttmacher study, among the 15 percent of American mothers who arrived at a hospital for delivery with no insurance, 10 percent had no prenatal care or obtained it late in the third trimester.

In addition to financial barriers, both pregnant women and health care providers report a series of other problems in gaining access to prenatal care. Non-financial barriers are often divided into three categories: public policy or systems barriers, provider barriers, and patient barriers.

Examples of **policy and systems barriers** include uncoordinated care, inconvenient clinic time and place, long waiting lists for visits, inadequate reimbursements levels and systems for providers, maldistribution of providers, malpractice and liability issues, and lack of transportation and child care.

Examples of **provider barriers** include the lack of cultural sensitivity on the part of the provider, inadequate education regarding the social and cultural aspects of care, inadequate awareness of community resources, and general communication problems between participant and provider.

Examples of **patient barriers** include the priority given to prenatal care compared to all other competing needs in a woman's life, denial and ambivalence about the pregnancy, illiteracy, lack of family or other support, fear of the system, fear of health care providers, and lack of knowledge of the importance of prenatal care.

THE COMPONENTS OF PRENATAL CARE

Prenatal care has been shown to decrease the incidence of low birthweight and other adverse pregnancy outcomes. The components of prenatal care that are considered effective in reducing risk and caring for pregnancy include

- risk assessment and case management,
- individualized care,
- nutrition counseling,
- education to eliminate or reduce health risks,
- social support services, and
- general health education.

In order to ensure the best possible pregnancy outcome, all factors contributing to an unhealthy pregnancy must be identified and acted upon early. As pregnancy progresses, the woman's risk status should be reassessed. At times, women who might have been initially identified as low risk develop problems that could place them at higher risk. Ideally, if a woman receives comprehensive prenatal care, identification and treatment of problems will take place and improved pregnancy outcomes will result. Both medical and behavioral/environmental factors are involved.

Medical Factors

Many chronic medical conditions become obstetrical risks, such as diabetes or hypertension, and can often be detected prior to pregnancy. Other risks, such as multiple pregnancies, cannot be detected before the prenatal care visit. Among the long list of medical factors that can adversely affect a pregnancy are certain maternal diseases, such as diabetes, syphilis, AIDS and other sexually transmitted diseases, asthma, hepatitis, hypertension, infections, cervical changes, placental problems, bleeding, and heart disease.

During prenatal visits, screening for many genetic and blood disorders can be done. The growth and development of the fetus and the mother's weight gain can also be tracked.

Behavioral and Environmental Factors

A woman's pregnancy can be endangered by factors that are not medical. In order for a caregiver to provide appropriate services, he or she must be aware of the much broader context of the pregnancy, both the environmental and behavioral context of the pregnant woman. Smoking and other substance abuse, poor nutritional status, exposures to toxic substances, stress, unemployment, lack of permanent housing, and lack of insurance each can adversely affect a pregnancy.

Other Factors

- Demographic risks, such as the mother's age, race, economic status, marital status, weight at birth, and level of education.
- Medical risks that predate the pregnancy, such as the number of children the mother has had; her weight for height; preexisting diseases such as diabetes; previous problem pregnancies including a previous low birthweight infant; and any maternal genetic factors.
- Health care risks, such as absent or inadequate prenatal care.

CONCLUSION

Over the decades, prenatal care has been considered an effective means of providing the "caring" a pregnant woman needs to ensure the healthiest possible pregnancy and infant. Prenatal visits are important, cost-effective encounters because they serve as the opportunity to assess the progress of a pregnancy and intervene when problems arise. Once the medical and other needs of the woman are known, the prenatal visit offers the opportunity to either directly provide services or refer the pregnant woman for any additional needed care.

REFERENCES

The Alan Guttmacher Institute, *Blessed Events and the Bottom Line: Financing Maternity Care in the United States, New York, 1987.*

American College of Obstetrics and Gynecologists, *Standards for Obstetric-*

Gynecologic Services, fifth edition, Washington, D.C., 1982.

American Nurses' Association, *Access to Prenatal Care: Key to Preventing Low Birthweight*, Kansas City, Missouri, 1987.

Institute of Medicine, *Preventing Low Birthweight*, National Academy Press, Washington, D.C., 1985.

Miller, A. C., *Maternal Health and Infant Survival*, National Center for Clinical Infant Programs, Washington, D.C., 1987.

U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future*, OTA-H-345, U.S. Government Printing Office, Washington, D.C., February 1988.

U.S. Congress, Office of Technology Assessment, *Neonatal Intensive Care for Low Birthweight Infants: Costs and Effectiveness*, Health Technology Case Study 38, OTA-HCS-38, Washington, D.C., December 1987.

U.S. Department of Health and Human Services, National Institutes of Health, *Report of the Expert Panel on Prenatal Care*, in press.

U.S. Department of Health and Human Services, Public Health Service, *Better Health for Our Children: A National Strategy*, the report of the Select Panel for the Promotion of Child Health, DHHS, Pub. No. (PHS) 79-55071, U.S. Government Printing Office, Washington, D.C., 1981.

U.S. Department of Health and Human Services, Public Health Service, *Promoting Health/Preventing Disease: Objectives for the Nation*, DHHS Pub. No. (OM) 81-0007, U.S. Government Printing Office, Washington, D.C., 1980.

U.S. General Accounting Office, *Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care*, HRD-87-137, Washington, D.C., September 1987.

THE FINANCING OF MATERNAL AND INFANT CARE

THE FINANCING OF MATERNAL AND INFANT CARE

A Summary

- A lack of financial resources is a primary barrier to receiving health care services, particularly preventive care such as prenatal and well-baby visits.

- A typical woman having a baby is in her early twenties, is in an entry level job, and has a yearly family income under $20,000. She may not be insured and probably has little savings with which to pay the average $4,300 bill for her maternity and hospital care and that for her baby.

- While most Americans can afford health care through having health insurance, nearly 20 million women of childbearing age and children are uninsured.

- The consequences of being uninsured are high. A 1987 General Accounting Office study found that 63 percent of uninsured women and Medicaid recipients obtained insufficient prenatal care. Almost twice as many of their infants were born at a low birthweight as compared to the national average.

- An estimated 27 percent of hospital uncompensated care costs are due to maternity and newborn care.

- Even those with private health insurance may have plans that do not meet their financial and/or health care needs. Most private insurance plans offer limited coverage with high cost-sharing for preventive services, such as prenatal and well-baby care.

- The rates of dependent coverage in employment-based insurance seems to be decreasing. Among children without insurance in 1985, an estimated 20 percent to 36 percent lived with a parent who had coverage through work.

- The federal Pregnancy Discrimination Act has helped to significantly increase the number of women with maternity insurance benefits; however, limitations in the law partially explain why five million women of reproductive age are uninsured for maternity care.

- Recent Medicaid expansions will allow more pregnant women and infants to become eligible; yet this alone will not ensure that all those eligible will come forward and apply. Effective ways must be found to reach this population, and problems with complex eligibility processes and low rates of provider participation, among others, must be overcome for the program to effectively serve these individuals.

- Proposed solutions to improving the financing of maternity and infant care include increasing employer-provided insurance coverage of maternity and well-baby care and expanding Medicaid coverage.

THE FINANCING OF MATERNITY AND INFANT CARE

The lack of financial resources has been identified as a primary barrier to receiving health care services, particularly preventive care, such as prenatal and well-baby visits. The value of these services, both for the health of mother and child and for their cost-effectiveness, cannot be overstated. Expectant mothers who do not receive adequate prenatal care are much more likely to have problems during pregnancy and to deliver a low birthweight baby than are those who do get adequate care. Infants without a regular source of care are more likely to not get immunized against infectious childhood diseases. Their parents are less likely to take them in for early treatment of illnesses or accidents which, when left unchecked, can progress to more serious conditions. Moreover, cost-conscious hospitals and other health care providers sometimes may refuse to treat individuals who cannot demonstrate an ability to pay.

Most Americans can afford health care services because they have health insurance coverage, either privately or through public programs such as Medicare and Medicaid. However, about 37 million individuals, including nearly 20 million women of childbearing age and children, do not have any health insurance; many others are underinsured because the plans they do have do not adequately cover their financial and/or health care needs.

Initiatives to close the gaps in health insurance coverage have been proposed for both the private and public insurance systems. For low income pregnant women and infants, eligibility for the Medicaid program has been expanded with the promise of reforming the entire program for this population. Yet, before this can happen, problems with complex eligibility processes and low provider participation, among others, must be overcome. Proposals have been made to offer incentives or mandate employers to provide health benefits to employees and dependents.

A typical woman having a baby in the United States is in her early twenties, in an entry level job, and has a yearly family income below $20,000. Compared to an older worker, she is more likely to be uninsured and to have limited savings with which to pay the $4,300 average cost of her maternity care and her newborn's hospital care. It is no surprise, then, that charges for maternity and newborn care account for over one quarter of all unpaid hospital bills.

A variety of policy options are available for improving the financing of health care for pregnant women and their infants. Such measures can significantly improve the health of mother and child and provide a more rational, cost-effective approach to paying for care than is possible with the current system.

PRIVATE FINANCING OF MATERNITY AND INFANT CARE

Private Health Insurance

The primary system of financing health care services in the United States is through private employment-based group health insurance. Coverage can also be purchased on an individual basis directly from an insurance company. This latter type of coverage is usually more expensive than employment-based or other group insurance where the insurance risk and, therefore, cost is spread among all members of the insured group.

- In 1985, 73 percent of the 56 million women of childbearing age (ages 15 to 44) had private health insurance: 67 percent were covered by group insurance and 6 percent had individual policies (see table 1).
- Of the 45 million children under age 13 in 1986, about 63 percent were reported to be covered by private health insurance, both group and individual policies (see table 1).

Health insurance is provided by various entities for groups as well as individuals: commercial insurance companies, Blue Cross and Blue Shield plans, Health Maintenance Organizations (HMOs), and Preferred Provider Organizations (PPOs).[1] In addition, large employers are increasingly self-insuring, assuming the full financial risk of health care costs for their employees.

The escalating cost of health care has caused all participants--insurers, governments, providers, and employers--to implement various initiatives to

Table 1
Sources of Health Insurance Coverage for Women of Childbearing Age and Children Aged 13 and Under

	Women aged 15-44[a]		Children aged 13 and under[b]	
Source of insurance	*Number (millions)*	*Percent*	*Number (millions)*	*Percent*
Private (group and individual)	40.9	73	28.4	63
Public (Medicaid, Medicare, Military Health)	5.6	10	7.2	16
Combination*			1.4	3
No insurance	9.5	17	8.1	18

**The Office of Technology Assessment calculated the number of children covered by a combination of public and private health insurance. These detailed data were not available from the Alan Guttmacher Institute study.*

SOURCES:
[a] *The Alan Guttmacher Institute, based on 1985 Current Population Survey.*
[b] *Office of Technology Assessment, based on 1986 Current Population Survey.*

control their costs. First dollar coverage in insurance policies is becoming less common, and the use of deductibles, coinsurance payments, and other cost-control mechanisms are being seen more often.

The cost of coverage is affected by these factors as well as whether one belongs to a group plan of a large or small employer or purchases coverage on an individual basis. For small group and individual policies, insurers evaluate whether the proposed insured will be accepted or rejected and whether certain specifications need to be built into the plan to limit the financial risk to the insurance company. This practice of underwriting tailors a plan to the insured group or individual. Limits can be placed on coverage of preexisting conditions, including pregnancy; waiting periods of 1 to many months can be imposed before coverage is effective, which can include pregnancy as well; and deductible and coinsurance payment levels can be set to discourage overutilization of services.

Because small employers and individuals face large costs for insurance or may be denied coverage due to pre-existing medical conditions, various pooling mechanisms have been developed to help them obtain insurance at an affordable price. For employers, such pools help simplify plan administration and lower premium costs because they spread risk across larger groups of individuals.

Limitations of Private Health Insurance

In 1978, the Congress passed the Pregnancy Discrimination Act (Public Law 95-555) to require employers to offer maternity care coverage to employees and their spouses in the same manner as other medical care coverage. This has helped to significantly increase the number of women with insurance coverage for these expenses. In 1977, only 57 percent of employees with new health insurance policies had maternity care benefits. By 1982, this had risen to 89 percent.

Even with such requirements, however, about 9 percent of women of reproductive age--5 million women--have private insurance that does not cover maternity care. The gaps in coverage can be attributed to a great extent to limitations in the requirements of the Pregnancy Discrimination Act. First, the law applies only to employment-based insurance (that purchased by employers from commercial carriers or Blue Cross and Blue Shield plans and that of self-insured businesses); individually purchased policies do not have such requirements. Second, only an employee and spouse are affected by the law; it does not mandate that the maternity care of a dependent pregnant teenage daughter be covered by her employed parent's policy. Finally, the law does not affect businesses with 15 or fewer employees.

As a result, simply having health insurance does not guarantee full financial protection against the costs of maternity and pediatric care. Numerous characteristics of insurance policies, such as those discussed above, can prove to be barriers to mothers and their infants receiving appropriate and timely health care. These factors can be important determinants of their ability to obtain needed care. Other important factors include:

- Limitations on certain types of covered benefits, such as preventive office visits (including prenatal care and well-child visits) and prescription drugs (such as antibiotics to treat a baby's ear infection) can undermine access to care.

- Trends in plans to shift more of the cost of insurance, especially dependent coverage, to the enrollees can be financially burdensome for a young family having a baby or with a new infant. Such increases include higher deductibles and higher percentages of premium costs borne by enrollees.

- An increasing share of the cost of employee and dependent coverage in employment-based plans is being paid by the employee. It has been suggested that this may cause lower income workers to not elect this coverage. Among children without insurance in 1985, an estimated 20 percent to 36 percent lived with a parent who reported having coverage through work.

- Exclusions from coverage or lengthy waiting periods before services are covered, such as pregnancy, for a new policyholder causes gaps in coverage. The Alan Guttmacher Institute found that 58 percent of workers with group coverage belong to plans that impose waiting periods of 3 months or more. For maternity care received during this time, coverage may be unavailable; in some instances, no coverage may be offered at all for a pregnancy diagnosed before the waiting period expires.

- Annual deductible and coinsurance payments can be prohibitively expensive. Cost-sharing is common for prenatal care and other preventive services, such as pediatric office visits. For young families, these expenses can be substantial and may discourage them from seeing a physician unless they are very ill.

- Insurers often make a single "global" payment to the physician after the baby is born for all prenatal, delivery, and postpartum care. Nonetheless, women often must pay for services as they are delivered during the course of their pregnancy. These large out-of-pocket expenses are not reimbursed until well after the delivery and affects the affordability of care.

The Federal and State Role in Private Health Insurance

The availability of private health insurance has been encouraged by a variety of laws and regulations which promote the purchase and affect the content of coverage. The federal Pregnancy Discrimination Act is but one of these.

Federal tax subsidies. Employer contributions to health insurance are excluded from the employee's taxable income. Employers can deduct their contributions to employees' health insurance as business expenses. The combination of these tax incentives has encouraged employers to provide health benefits. Today, about two-thirds of Americans under age 65 are covered by employer-sponsored plans.

Health insurance expenses of self-employed individuals and unincorporated businesses, however, do not receive the same tax treatment as those of incorporated businesses. Although individuals who are self-employed or who own unincorporated businesses are able to deduct 100 percent of their contributions to employees' health insurance, until the Tax Reform Act of 1986 none of their own insurance expenses were deductible. Because this has been seen as a disincentive to these typically small businesses offering health insurance to employees as well, the Tax Reform Act allowed for a 25-percent deduction for these employers' health insurance expenses.[2]

Finally, individuals who itemize deductions on their income taxes can deduct from their taxable income any qualified unreimbursed medical expenses, including health insurance costs, that exceed 7.5 percent of their adjusted gross income.[3]

Federal regulation of employee welfare benefit plans. Although states generally regulate insurance, employee welfare benefit plans are governed by the federal government under the Employee Retirement Income Security Act of 1974 (ERISA) (P.L. 93-406). Employers offering health benefits through a self-funded (or self-insured) means assume the financial risks for the health care of their employees. These health benefit plans are exempt from state mandates that apply to conventional health insurance. ERISA does provide some regulation of self-insured plans but, in general, employers have a great deal of leeway in structuring these plans. Forty percent of medium and large employers self-insure.

Continuation of health insurance coverage. Concern about employees and their families losing coverage upon termination of employment, a reduction in hours, or a change in marital status, prompted the Congress to pass health insurance continuation provisions in the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) (P.L. 99-272). Businesses with 20 or more workers must make group coverage available to certain former employees and dependents for a specified amount of time (18 or 36 months) with either the employer or enrollees paying the full premium cost at the employer's discretion.

State mandated benefit laws. The regulation of insurance has traditionally been a state responsibility. According to reports by the Blue Cross and Blue Shield Association, there are over 600 state-mandated benefit laws governing health insurance, including services to be covered, specific providers eligible for reimbursement, and requirements governing conversion and continuing coverage options. The federal Pregnancy Discrimination Act requires coverage of maternity care for most employees and spouses. In addition, various state laws prohibit discrimination in private insurance policies concerning maternity benefits. All states require that insurance policies include coverage of a newborn for illness from the moment of birth. However, very few require coverage of necessary well-baby care and some even specifically exclude such care from their requirements.

MEDICAID FINANCING OF MATERNITY AND INFANT CARE

Medicaid, Title XIX of the Social Security Act, is the largest source of public funding of maternal and child health care.[4] In fiscal year 1987, $50.0 billion were spent on health services for the nearly 25 million Medicaid beneficiaries. The federal share was estimated at $27.4 billion; the states', about $22.5 billion.

- In 1985, 17 percent of all births were covered by Medicaid. Federal and state Medicaid payments totaled $1.8 billion for maternity care.
- Children under age 21 represented about 50 percent of all Medicaid recipients in 1985; Medicaid payments for children under age 21 were $8.0 billion.

Funding and Administration

Medicaid is financed by the federal and state governments. In some states, local governments contribute as well. The federal Medicaid contribution ranges from 50.0 percent to 79.7 percent, depending on the average per capita income of a state's residents. The average federal share was 54 percent in fiscal year 1987.

Although jointly financed by the federal and state governments, states design and administer their own Medicaid programs, functioning within broad federal guidelines. Consequently, significant interstate variations exist along important program areas: eligibility requirements, benefits provided, and provider reimbursement policies. States have the option to extend Medicaid coverage to individuals and for services beyond those required by the federal guidelines. States can also obtain waivers of certain federal requirements for the purpose of tailoring services for specific groups of beneficiaries. While the variability across state lines has created inequities in eligibility and coverage, it has also offered flexibility and innovation in the Medicaid program. Historically, states have taken the lead in developing innovative strategies to serve their Medicaid population.

Medicaid's ability to assure access to health care for poor people, especially childbearing women and children, depends on these state-specific features.

Eligibility

States are required to cover specific categories of individuals: certain low-income families receiving

Aid to Families with Dependent Children (AFDC) and individuals who are very poor and also at an advanced age or disabled. Recent amendments to Medicaid, which will be discussed later, have added new groups of eligible pregnant women and young children. Each state sets its own income guidelines by which individuals qualify for Medicaid. As a result, eligibility varies significantly from state to state.

- On average in 1988, a family applying for AFDC had to have an income of less than 48 percent of the federal poverty level to qualify.[5]
- Eligibility income levels vary greatly by state, ranging from a low of 14.6 percent of poverty ($1,416) in Alabama to 85.8 percent ($8,316) in Utah for 1988.

States may also offer Medicaid to the "medically needy," those who meet the criteria for categorical eligibility except that their family income and resources are just above the applicable level. Families with incomes even higher than the medically needy limits may also become eligible by "spending down" to the medically needy level if their medical expenses reduce their incomes below the medically needy limits. Thirty-five states and the District of Columbia have medically needy programs.

Services

States must cover certain services according to federal guidelines: inpatient and outpatient hospital, rural health clinic, laboratory, x-ray, pharmacy, family planning, physician, and certified nurse midwife services. Many of these are important to the prenatal, delivery, and postpartum needs of women and the health needs of their infants.

Children eligible for Medicaid are covered for a range of well- child services that greatly exceeds those generally covered by private insurance plans. Well-baby or well-child care is provided through Medicaid in two ways: through the basic state Medicaid plan and also through the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program. States are mandated to offer this program of preventive and comprehensive services to children up to 21 years of age. Total spending for EPSDT in fiscal year 1987 was $139.7 million. Services include health, developmental and nutritional assessments, physical examinations, immunizations, vision and hearing screenings, certain lab tests, and dental services.

While the EPSDT program could provide for a comprehensive set of well-child services, in most states it falls short of its potential.

- In fiscal year 1985, only 18 percent of eligible children were served through EPSDT, the same percentage as in fiscal year 1981.
- Even when newborns or older children are eligible for Medicaid, they do not automatically receive EPSDT services. EPSDT is optional under Medicaid and many families do not sign their children up for the program.
- In many states the EPSDT program is not well integrated into the primary health care system; screening sites are usually separate from children's regular source of care and reimbursement for EPSDT services is generally low.
- Although some may do so, states are not required to offer follow-up care as indicated in the screenings that are above and beyond the limits on services already covered in the state's Medicaid plan. However, offering coverage for these additional services increases the probability that the infant or child's health problems identified through EPSDT would be addressed by the family and their primary care provider.

Medicaid Coverage of Pregnant Women, Infants, and Children

Since the mid-1960s, expectant mothers have significantly increased their use of prenatal care and infant mortality has been dramatically reduced. Medicaid coverage for health care services for poor pregnant women and infants over the past 2 decades has been a factor in the improvements in these health care and health status indicators.

- In 1969, 68 percent of women began prenatal care during the first trimester of pregnancy; by 1985, 76 percent of women began prenatal care during their first trimesters.
- In 1965, the total U.S. infant mortality rate was

24.7 deaths per 1,000 live births; by 1985, it was 10.6. Over the same years, the white rate was reduced from 21.5 to 9.3; the black rate fell from 41.7 to 18.2.

Recent Medicaid Changes for Pregnant Women, Infants, and Children

Medicaid Expansions. Beginning with the Deficit Reduction Act of 1984 (P.L. 98-369), the Congress expanded Medicaid coverage for pregnant women and infants and young children through mandates and new options for the states. Many factors have led to policymakers' actions to increase Medicaid's responsibility for financing prenatal and young children's health care.

- Federal changes in AFDC eligibility rules in the early 1980s and state actions to limit the growth of their Medicaid programs has resulted in Medicaid's coverage of the poor eroding over the years. Only 38 percent of persons living below the federal poverty line are currently covered. The average 1988 state income threshold for eligibility is 48 percent of federal poverty; it was 71.4 percent of poverty in 1975.
- A lack of financial access has been shown to be a primary reason for the failure of many low income women to obtain prenatal care.
- Prenatal care is cost-effective, lessening the chance that a newborn will be born ill and in need of expensive neonatal intensive care.
- In recent years, improvements in the U. S. infant mortality rate have been minuscule (10.8 in 1984; 10.6 in 1985), and the U. S. rate has fallen to last place among 20 industrialized countries. This country's low birthweight rate, 6.8 percent in 1985, has hardly improved since 1950 when it was 7.5 percent.
- Large racial disparities exist in infant mortality rates in the United States. For many years, the black rate has been twice the white rate.

Legislative actions have begun a process of overall program reform and have helped initiate the significant step of uncoupling Medicaid and the AFDC welfare program.[6]

- Medicaid coverage is currently mandated for all pregnant women with family incomes and resources below state AFDC financial eligibility requirements.
- Medicaid eligibility for pregnant women meeting AFDC standards must be extended through 60 days postpartum (post-delivery). States have the option of offering continuous eligibility for pregnant women with incomes above the AFDC level.[7]
- States also must cover all children up to age 7 (or 8, at a state's option) who were born on or after October 1, 1983, and who meet AFDC standards on a yearly phased-in basis (OBRA-87, P.L. 100-203).
- For children with slightly higher family incomes, states have the option of offering Medicaid to children between ages 1 and 5 (on a yearly phased-in basis) with incomes at a state-determined level which can be as high as 100 percent of federal poverty (OBRA-86, P.L. 99-509) (see app. 1).
- Effective July 1, 1990, all states must cover pregnant women and infants to age 1 with family incomes at or below 100 percent of federal poverty (P.L. 100-360).
- For pregnant women and infants with slightly higher incomes, states have the option of offering Medicaid coverage to those whose family incomes are above 100 percent but are not more than 185 percent of poverty ($17,930 for a family of three in 1988) (OBRA-87, P.L. 100-203).[8] In an effort to encourage more states to take this option, a provision was included to allow small premiums to be charged for the coverage for individuals with incomes between 150 percent and 185 percent of poverty.
- Imposing assets or resources tests, required for those applying for AFDC, is optional for individuals in these new eligibility groups who are applying for Medicaid only (OBRA-86, P.L. 99-509).[8]
- States may offer enriched benefits, including case management (outreach, care coordination, and referrals to other community resources), to pregnant women without extending them to other Medicaid eligibles (COBRA, P.L. 99-272).

- States may offer temporary "presumptive eligibility" to pregnant women while their formal application for Medicaid is being processed (OBRA-86, P.L. 99-509). Presumptive eligibility will be further discussed below.

Delinking Medicaid and Welfare

These expansions of Medicaid reflect a significant departure from previous program changes and are considered vital to creating a more comprehensive and complete system of financing health care services for poor pregnant women and children. Historically, Medicaid eligibility has been strictly tied to eligibility for welfare. As such, Medicaid has a welfare stigma attached to it: many low-income people do not want to "go on welfare" nor face the bureaucratic application process and other hurdles involved with the program. In addition, some do not know the program is available. Even with the recent expansions, many are eligible but may not know that they are. Recent Medicaid expansions reflect a growing public interest in helping Medicaid become a more appealing and effective public health insurance program for pregnant women and young children.

Presumptive Eligibility

The Medicaid eligibility determination process in most states is complex with application forms and procedures long and frustrating for individuals applying for the program. The purpose of presumptive eligibility is to eliminate barriers to the timely receipt of prenatal care and open the program up to more pregnant women.

A qualified provider (the law specifies the type of providers who can become qualified) can determine in a streamlined way that a pregnant woman's income meets the state's eligibility level and if it does, she immediately becomes eligible for Medicaid for a period that can continue up to 45 days or until her formal application is accepted or denied, whichever is sooner. Any covered pregnancy-related services are available to her during this time regardless of the outcome of the formal eligibility determination.

- Medicaid eligibility applications forms can run as long as 54 pages. They are difficult and time consuming to fill out and, once completed, a determination of one's eligibility can take over 6 weeks. Such delays can result in a woman not receiving care during the critical early pregnancy period. With presumptive eligibility, at least the initial application form can be short since it is income-based only and care can begin immediately.

- Because Medicaid payments are unpredictable or may be retroactively denied for services rendered while a woman's application is being processed, a low-income woman may have difficulty finding an obstetrician to care for her. Presumptive eligibility can ensure that the services rendered will be paid for while the full eligibility determination is in process.

Nineteen states have adopted presumptive eligibility (see app. 1). Others have or are considering shortening their Medicaid eligibility forms and processes in other ways to streamline and expedite the process.

Outreach Strategies

Eligibility for Medicaid does not mean that all potential recipients come forward to apply. The Congressional Budget Office estimates that of all pregnant women and infants with incomes below the federal poverty level, only 72 percent (68,000) of women and 76 percent (240,000) of infants would participate if all states expanded their Medicaid programs to cover these individuals.

Many women do not know Medicaid is available, and some refuse it because they do not want to accept welfare. To reach potentially eligible women and children, a number of states have undertaken formal outreach programs that include activities such as statewide media information campaigns, toll-free hotlines, and networks of community organizations that disseminate information and refer potentially eligible individuals.

Outreach efforts on this scale are new and have not yet been fully evaluated. Innovative and effective ideas may be fostered through the analyses of these programs being conducted by the Institute of Medicine and the National Governors' Association.

Remaining Barriers to Maternity and Infant Care Under Medicaid

Despite the availability of Medicaid coverage, federal requirements and state decisions regarding the types and amounts of services covered and payment levels for such services still create significant barriers to care.

Eligibility. States vary greatly in their income eligibility requirements for Medicaid. However, the federal legislation mandating state coverage of all pregnant women and infants with incomes below the federal poverty level, which will become effective over the next 2 years, will set an eligibility floor for these groups and help alleviate some of these difficulties. This is not the case for older children, however, nor for low-income individuals whose incomes are even slightly above the federal poverty guidelines.

The process for determining one's eligibility is also a barrier to receiving Medicaid benefits. A recent study that covered the 17 southern states found that the amount of paperwork, documentation, and other administrative complexities discourage potentially eligible individuals from filing a formal application until confronted with a serious health problem. Such difficulties defeat efforts to promote preventive health care.

- Nationally, about 60 percent of all Medicaid eligibility denials are due to "Failure to Comply with Procedural Requirements" (such as not filling out forms, not keeping appointments, and lacking complete financial records). These denials are much more common than are those for reasons such as excessive income (21 percent) or resources (4 percent).

Limitations on Covered Services. While federal regulations require states to cover certain services, beyond this states set their own coverage rules which vary tremendously across the country. A state can limit the frequency and number of services. For instance, it can limit the number of physician visits or hospital days it will pay for in 1 year.

- 10 states set limits on the number of hospital outpatient or physician visits that were less than the 12 to 13 prenatal care visits recommended by the American College of Obstetricians and Gynecologists (ACOG).

States can also cover optional services, such as clinic services, prescription drugs, and diagnostic tests, many of which would be important features of comprehensive prenatal care. Yet, in many states these services are not covered.

Low Physician Participation in Medicaid. Limited physician participation in Medicaid has long been recognized as a major barrier to poor pregnant women receiving appropriate prenatal care.

- A 1987 study by the Office of Technology Assessment reported that Medicaid participation by obstetricians/gynecologists lags behind other specialties, while pediatrician participation is about average among all medical specialties.

- A 1987 survey of members by ACOG showed that only 64 percent of respondents reported participating in Medicaid.

- A survey of pediatricians published in 1986 reported that 82 percent of pediatricians participated in Medicaid in 1983.

An important factor in physicians' refusal to participate in Medicaid is low reimbursement for services. Not only are Medicaid payments lower than private third-party payment levels in nearly every instance, but substantial variation exists between state programs as well.

- While in 1987 the average Medicaid global (total) payment rate for maternity care (includes prenatal, vaginal delivery, and postpartum care) was $596, state rates varied greatly, ranging from $236 in New Jersey to $1,471 in Massachusetts.

- An ACOG survey found the median physician charge for total maternity care to be $1,000 in 1986, with the averages ranging from $840 in the rural Midwest to $3,422 in a large city in the East.

In addition, Medicaid payments may be delayed and unpredictable. If a pregnant women or her child loses Medicaid eligibility due to an increase in income, the provider risks not being paid. Also, the amount of documentation required of providers by federal and state regulations can be time-consuming and burdensome.

In recent years, some states have responded to their provider participation problems by increasing Medicaid payments for maternity care and lessening administrative requirements. Still, payments remain well below private third party levels and growing concern about medical malpractice costs are causing states, providers, and patients to grapple with new issues affecting access for low-income individuals.

One of the most significant issues concerning access to care for pregnant women, especially for those on Medicaid, is the rising cost of liability insurance for all maternity care providers, particularly obstetricians/gynecologists. Professional malpractice and liability insurance costs alone can constitute a large portion or exceed the Medicaid reimbursement rate for obstetric services, creating another disincentive for treating Medicaid patients or other low-income individuals.

Some obstetrical providers believe that caring for Medicaid patients increases their vulnerability to lawsuits. This perception, however, has been neither substantiated nor disproved by empirical evidence. Nonetheless, access to care, particularly from private practitioners, is being affected by the current medical malpractice situation. Survey data from provider organizations and others clearly indicate that physicians are lowering their participation in public programs due to increases in malpractice insurance costs, creating significant access problems for low-income women, especially in rural areas.[9]

FINANCING MATERNITY AND INFANT CARE FOR THE UNINSURED

While significant gaps exist in private health insurance coverage for maternity and infant care, an estimated 37 million people-- nearly 18 percent of all Americans--have no health insurance at all.[10] This group consists of individuals who lack private health insurance but who do not qualify for public assistance, particularly Medicaid. Nearly everyone over 65 is covered through the Medicare program.

- 17 percent (9.5 million) of all women of childbearing age lacked health insurance in 1985 (see table 1).
- An estimated 18 percent of children under age 13-- nearly one in five--had no health insurance in 1986 (see table 1).

The proportion of those under age 65 without insurance has increased from nearly 15 percent in 1979 to almost 18 percent in 1986. There are a number of possible explanations for this trend. The rate of dependent coverage is declining. Cost-conscious employers are less likely to offer this coverage at all or are contributing less for the premiums and employees are choosing to not purchase the coverage. Changing demographics is another possible explanation. Children under 18 make up a smaller part of the population now than they did in 1979; older children in the household may not be eligible for coverage under their parents' policies. Other explanations for the growth in the uninsured population may be the shift in the economy from manufacturing to service industry jobs and an accompanying shift in jobs from large to smaller employers. Both the service sector and small employers are less likely to offer health insurance.

The Working Uninsured

The majority of the uninsured are employed and are often referred to as the "working poor." Uninsured workers and their dependents account for 70 percent to 81 percent of all Americans without health insurance coverage. Small businesses are less likely to offer health insurance than are larger employers.

- In 1985, 75 percent of uninsured workers earned less than $10,000 and nearly all (93 percent) earned less than $20,000.
- 98 percent of businesses with 100 or more employees offer health insurance, compared with 55 percent of employers with fewer than 100 employees.
- Almost half of all uninsured workers are in firms with fewer than 25 employees.

Employers frequently cite insufficient profits to pay for insurance and the high cost of insurance premiums as the main reasons for not offering health insurance. Additional factors include high employee turnover, inability to qualify for group insurance rates, high administrative costs, and employees' lack of interest as explanations for not offering coverage to their employees.

Current Financing of Care for the Uninsured

The uninsured or those who are insured but are unable to pay their cost-sharing amounts do receive care. Their maternity and infant care is receive care. Their maternity and infant care is financed through a variety of public and private means.

Indigent care programs. State and local governments have indigent care programs that operate in one of two ways. A third party payment system, a "state only Medicaid program," is financed with state funds only, and individuals with incomes and assets slightly above the Medicaid limits can be eligible. States and local governments also provide operating support for free care providers, such as public hospitals and their outpatient clinics. These are important sources of care for poor women and children.

Uncompensated care. Providers offering free care, particularly public hospitals, pay for this charity care and bad debt, known as uncompensated care, by cross-subsidies to third party payers (also called cost-shifting). Financing care for those who do not pay through subsidies by those who do has been a longstanding practice in health care. However, payers are becoming more prudent in their health care purchases and less willing to bear their current share of subsidies for the uninsured population. Because of this factor plus reduced state and federal funds for health programs and a limited ability at the local level to increase the tax base, providers are finding it increasingly difficult to finance care for the uninsured.

These changes can have particularly severe consequences for poor pregnant women and their newborns. Maternity and newborn care constitute the largest single source of uncompensated hospital care. About 27 percent of the $7.4 billion in unpaid hospital charges in 1985 was for these services. Cost containment measures are changing the way health care for the growing number of uninsured and medically indigent is financed, and it is sparking interest among policymakers to devise other ways of financing care for these persons. Some of the options being proposed will be discussed later.

Out-of-pocket payments. While the uninsured often have lower total health expenditures, their out-of-pocket costs are higher than those of the insured. For example, one study found that among employed individuals in fair or poor health, the uninsured paid almost twice as much out-of-pocket as the insured each year for their health care.

Philanthropy. Community groups and foundations offer donations to public and private institutions to supplement the funds available to pay for the care of the medically indigent and help cover uncompensated care costs.

Federal and state grant programs. The federal government has a variety of programs that subsidize state programs and local providers to assure care for the uninsured and indigent. States can appropriate funds targeted for a specific population or program, such as pregnant women and children, to improve their access to primary care services.

A significant proportion of American women and infants without health insurance as well as those on Medicaid obtain their prenatal and well-baby care at publicly subsidized clinics. Three federal programs support clinics that provide care to both expectant mothers and their children: the Maternal and Child Health (MCH) Block Grant program, the Community Health Centers program, and the Migrant Health Centers program.

- 1.3 million patients of Community and Migrant Health Centers are women of childbearing age; 2.1 million are children under the age of 15.
- The Alan Guttmacher Institute found that, in 1986, 66 percent of women served by MCH clinics and Community and Migrant Health Centers had no insurance; 34 percent were covered by Medicaid.
- A total of 660,000 women, or nearly 1 in 5 of the 3.7 million women who give birth each year, obtain prenatal care at MCH clinics or Community or Migrant Health Centers.

Such clinics are important sources of care for the uninsured and Medicaid populations. Yet, their ability to serve those in need is limited. Public funding levels are low, resulting in limitations in the numbers that clinics can serve and long waiting lines for those they can. Clinics may not be located conveniently for those who need care, particularly for rural and inner city residents. Hiring providers can also be difficult, given the amount of funds available with which to pay salaries and increasing malpractice insurance rates.

100

Recognizing the importance of Community and Migrant Health Centers in delivering prenatal care to low-income women, a group at high risk of poor birth outcomes, the Congress appropriated $20 million in fiscal year 1988 for an Infant Mortality Initiative in these two programs (P.L. 100-202). The Initiative offers grants to qualifying centers for the purpose of improving and expanding maternal and infant health services designed to reduce infant mortality.[11]

The Effects of Being Uninsured

The consequences of so many individuals being uninsured are high, both in terms of access to health care as well as costs to society.

Lack of preventive care and increased incidence of low birthweight. The lack of insurance is a major reason for not obtaining health care. A 1986 Robert Wood Johnson Foundation national survey on access to health care found that:

- Nearly twice as many (31 percent) of the uninsured had no regular source of health care compared to the insured (16 percent).
- 68 percent of the uninsured who reported serious health symptoms went without care (had not seen a physician in the past 30 days), compared to 39 percent of the insured.
- Over three times as many of uninsured (19 percent) reported that immunizations were not up to date for their children under age 5, compared to the insured (6 percent).

This and other studies have found that the uninsured use fewer preventive health services, such as prescription drugs, ambulatory physician visits, and hospital stays, than those with private insurance, Medicaid, or Medicare, but they use hospital emergency rooms as regular--and expensive--sources of care more often than the insured.

Preventive health care in appropriate settings is valuable for promoting healthy practices, such as not smoking or drinking during pregnancy and immunizing children against infectious childhood diseases, and treating minor ailments which, when left unattended, could require expensive hospital treatment. Numerous studies have demonstrated that early and appropriate prenatal care is associated with the reduced incidence of low birth weight. Low birthweight infants are likely to require expensive neonatal intensive care, a cost that often could be avoided if the infant's mother receives adequate prenatal care.

- A 1987 General Accounting Office study found that more than twice as many (81 percent) privately insured women began prenatal care in the first 3 months of pregnancy and made nine or more prenatal visits than did those with Medicaid coverage (36 percent) or those with no health insurance (32 percent). Of the babies born to the Medicaid beneficiaries and uninsured women in that study, almost twice as many (12.4 percent) had low birthweights compared to the national average (6.8 percent).
- The Office of Technology Assessment estimated that for every low birthweight birth averted by earlier or more frequent prenatal care, the U.S. health care system saves between $14,000 and $30,000 in newborn hospitalization, rehospitalization, and long-term health care costs associated with low birthweight.

Patient dumping. Women without insurance may be denied hospital admission or are transferred to other facilities because of their inability to pay for care. This is known as "patient dumping." Reports of individuals, including women in active labor, being denied hospital admission prompted the Congress to prohibit the practice of dumping patients in a medical emergency or active labor through a provision in COBRA of 1985. The patient can be transferred if the physician in charge states in writing that the hospital cannot treat a condition and the benefit of transfer outweighs the risk. The law does not, however, prevent hospitals from refusing care to women in early stages of labor or with pregnancy complications before labor begins.[12]

Hospital preadmission deposits. Another consequence of a lack of insurance is that a pregnant woman is often required to pay a preadmission deposit of $500 to $1,000 to the hospital prior to her delivery. If she cannot afford this, she is not allowed to register for admission and is compelled to enter as an emergency patient once her labor begins. In these instances, the admitting physician probably does not have her records and is unfamiliar with her case. The inability to pay these deposits leads to fragmented care which has also been identified by obstetricians as adding to their liability when providing services to these low-income individuals.

PUBLIC POLICY OPTIONS TO INCREASE HEALTH INSURANCE COVERAGE

Access to health insurance is critical to obtaining access to health care. The current system of financing health care in the United States leaves many Americans vulnerable, and the number of uninsured individuals has been increasing in recent years.

Various options to reduce the number of uninsured persons have been proposed on a state and national level. While a complete restructuring of the health care financing system has been discussed, the likelihood of that happening in the short term is remote. Given that, most proposals focus on a "fill-in-the-gaps" approach to providing health insurance coverage to uninsured Americans.

Among the many options being discussed are:

- Increasing the role of employers in providing health insurance to their employees and dependents, either through additional tax incentives or mandated coverage.
- Expanding Medicaid eligibility for the nonworking or low wage-earning uninsured.
- Creating health insurance pools for target groups, such as small businesses and medically uninsurable individuals.

Mandated Employer-provided Health Insurance

The most frequently discussed national level proposal to require employers to provide health insurance benefits is the Minimum Health Benefits for All Workers Act of 1988, (S.1265, Kennedy; and H.R. 2508, Waxman).[13] Among other things, the bill would require employers to provide employees who work 17.5 or more hours a week and their dependents with insurance for hospital, medical, surgical, maternity, and well-baby care. The employer would pay at least 80 percent of the premium cost, although employers would pay 100 percent for workers making less than 125 percent of the minimum wage. No cost sharing could be imposed for prenatal and well-baby care. The bill also contains provisions for catastrophic protection (limiting out-of-pocket costs to $3,000 per household) and for allowing small businesses to join regional pools to help them obtain lower premium rates than would be available if they were purchasing insurance on their own.

An estimated 23 million working Americans and their families would become insured through this legislation. The cost of the bill and its potential impact on the economy, particularly small businesses, have received wide attention and debate. The Congressional Budget Office has estimated the first year total cost of the bill to be about $27 billion for the additional insurance policies that would have to be written; a net reduction in federal outlays would total about $5 billion and federal revenues would fall by about $6 billion.14 The CBO also estimated that requiring new coverage could result in a gross loss of about 100,000 jobs. Other studies have projected these costs to be higher.

Expanded Medicaid Coverage

Although the Medicaid program was designed to provide the poor with access to mainstream health care, it is currently estimated to cover less than 40 percent of Americans with incomes below the federal poverty level.

While the program has been expanded in recent years to improve coverage of health services for pregnant women and young children, many remain uncovered. Also, because outlays for long- term nursing home care for the elderly and disabled are increasing as that population grows in size, states often believe their ability to do more to improve coverage for younger recipients is limited. The congressionally sponsored expansions of Medicaid for pregnant women and infants, however, signal continuing interest in improving financial access for this population through the Medicaid program.

Proposals have been developed to broaden Medicaid's role in filling some of the gaps for low-income families, both with unemployed and low wage-earning heads of household. One option would be to offer a "Medicaid buy-in" which would make coverage available by paying a premium based on income. Individuals, employed or unemployed, and employers could contribute to an income adjusted premium for purchasing Medicaid coverage.[13] Benefits could be tailored to the health care and financial needs of this higher income group. An important consideration when evaluating this type of solution for covering the uninsured is its potential impact on employers' willingness to purchase or provide health insurance benefits through the private market.

Other Proposals

A variety of other proposals, primarily directed to the private sector, have been offered to expand health insurance coverage which would also increase coverage for maternity and infant care. Briefly, these include:

- Closing "loopholes" in the Pregnancy Discrimination Act so that maternity care is covered for all women insured under private plans, including non-spouse dependents.
- Insurance pooling mechanisms which provide "group" coverage to previously ungrouped entities, such as small businesses, brought together by an insurer, agent, broker, or administrator.
- State risk pools to help provide health insurance to an estimated 1 million to 2 million medically uninsurable individuals.
- Additional tax incentives for self-employed workers and unincorporated businesses to offer health benefits to employees. Recent legislative proposals would allow tax deductions of 80 percent to 100 percent of the cost of health insurance for these employers and their employees, as is available for incorporated businesses.

CONCLUSION

The inability to pay for care is the primary barrier to receiving health care services. The system of financing health care in the United States is a patchwork of various private insurance plans and public programs that have differing eligibility rules depending on income, family structure, age, disability, and state of residence. As a result, close to one in five Americans lacks health insurance coverage through either private or public means. Nearly 20 million women of childbearing age and children under age 13 are uninsured.

The cost of having a baby is substantial for the average woman giving birth in the United States. She is young, her annual family income is low, and she is likely to be without insurance. Families with infants and young children often have similar financial and insurance characteristics. The costs of being uninsured are substantial, both to the individual and society, and the high costs of care must be borne either directly or indirectly by the public and private sectors and, ultimately, by every taxpayer and consumer. The cost-effectiveness of maternity and infant care has been well documented, and the Congress, some states, and some in the private sector, have begun to increase their roles in helping this group of vulnerable individuals improve their access to health insurance.

Because of the heterogeneity of the uninsured population, many solutions to financing their health care are possible. The majority of uninsured persons are employed workers or their families, and options to expand health insurance coverage often focus on private sector, employment-based initiatives. Expanding Medicaid coverage is another viable option. Short of a major restructuring of the health care financing system--which is unlikely in the near term--solutions for providing improved health care coverage will no doubt involve a combination of these proposals.

NOTES

1. According to a 1987 survey by the Alan Guttmacher Institute, 14 percent of participants in employment-related plans (including 5.3 million women) are covered through HMOs and PPOs. An HMO, in return for prospective capitated payments, acts as both an insurer and provider of care. Because payments are fixed, HMOs have a financial incentive to focus on preventive care and early interventions, such as prenatal care services and well-baby care. PPOs are medical groups with whom an employer has made an agreement to offer certain services at a predetermined reduced rate. Policyholders are encouraged to obtain care from these preferred providers.

2. This provision is scheduled to expire on December 31, 1989. Because this 25-percent deduction is still less than the full deduction allowed corporations, some view this as not enough of an incentive for businesses to offer insurance. Legislation has been introduced in the Congress

to allow up to a 100-percent deduction for the self-employed and unincorporated businesses.

3. This amount had been 5 percent prior to enactment of the Tax Reform Act of 1986 which increased it to 7.5 percent, making this tax benefit available to fewer individuals than in the past.

4. In addition to Medicaid, a number of government health care financing programs cover particular groups of individuals, including mothers and children. The federal, state, and local governments provide health insurance for their employees. Two of the largest are the Federal Employees Health Benefits Program and the Civilian Health and Medical Program of the Uniformed Services for military employees, retirees, and their dependents. For qualifying disabled women, Medicare also finances maternity care.

5. The federal poverty level in 1988 is $9,690 for a family of three. Forty-eight percent of this is $4,651.

6. Traditionally, qualifying for AFDC confers automatic Medicaid eligibility. Some states have recently expanded Medicaid eligibility for pregnant women and children with incomes above state AFDC eligibility levels. These individuals do not also receive cash benefits through AFDC.

7. As of July 1988, 37 states had implemented programs that will guarantee uninterrupted coverage throughout an eligible woman's pregnancy and postpartum period, regardless of fluctuations in her family income or resources (see app. 1).

8. As of July 1988, 33 states had or soon will expand Medicaid eligibility for pregnant women and young children with family incomes up to 100 percent of poverty; another 10 have opted to increase the income level further to some point between 100 percent and 185 percent of poverty, and 34 have dropped assets or resource tests for these newly eligible groups as well (see app. 1).

9. For further discussion, see *Malpractice and Liability: An Obstetrical Crisis,* published by the National Commission to Prevent Infant Mortality. Also, the National Governors' Association is conducting a survey of state Medicaid and Maternal and Child Health agencies which should provide additional data on the severity of the problem of provider participation in programs serving mothers and children and the degree to which the malpractice situation is affecting this problem.

10. Estimates of the uninsured under age 65 range from 22 million, based on a 1986 national health care access survey by the Robert Wood Johnson Foundation, to 37 million, based on the Bureau of the Census' annual Current Population Survey. Another often-quoted estimate of the uninsured is 35 million, developed by the Employee Benefit Research Institute. It is also based on the Current Population Survey, but excludes agricultural and military populations.

11. Funding for the Infant Mortality Initiative is expected to continue in fiscal year 1989. For further discussion of the MCH Block Grant program and the Community and Migrant Health Centers programs, see the Issue Briefs on each in this volume.

12. The Subcommittee on Human Resources and Intergovernmental Relations of the House Committee on Government Operations held a hearing on July 22, 1987, on the progress being made by the Department of Health and Human Services in implementing and enforcing the anti-dumping law (Committee Report 100-531). One concern expressed by the Subcommittee was that the Department had not published regulations to implement the antidumping statute. On June 16, 1988, proposed regulations were published in the Federal Register.

13. Hawaii requires all employers to provide health insurance coverage. In April 1988, legislation was enacted in Massachusetts to provide for universal health care coverage for all residents of that state. The law is to be fully implemented in 1992.

14. Because all workers would participate in employment-based plans, savings would be realized in the Medicare, Medicaid, and CHAMPUS programs as these employment-based plans became the primary payers. Federal costs would rise in the Federal Employees Health Benefits Program since federal workers currently without that coverage would have to be covered. The drop in federal revenues would result from lower income tax collections and lower payroll tax revenues from Social Security and Medicare.

15. Legislation based on such a concept has been introduced in the Senate, The MedAmerica Act of 1987 (S.1139, Chafee).

REFERENCES

The Alan Guttmacher Institute, *Blessed Events and the Bottom Line: Financing Maternity Care in the United States,* New York, 1987.

The Alan Guttmacher Institute, *The Financing of Maternity Care in the United States,* New York, December 1987.

American Academy of Family Physicians, "A Professional Liability Study," Kansas City, Missouri, 1987.

American College of Obstetricians and Gynecologists, "Professional Liability and its Effects: Report of a 1987 Survey of ACOG's Membership," Washington, D.C., March 1988.

Cislowski, Joseph A., *Health Care for Children: Federal Programs and Policies,* 88-217 EPW, U.S. Library of Congress, Congressional Research Service, Washington, D.C., June 16, 1988.

Congressional Research Service, *Health Insurance and the Uninsured: Background Data and Analysis,* U.S. Library of Congress, Washington, D.C., June 9, 1988.

Employee Benefit Research Institute, "A Profile of the Nonelderly Population without Health Insurance," *EBRI Issue Brief*, No. 66, May 1987.

Employee Benefit Research Institute, "Employer-Sponsored Health Insurance Coverage," *EBRI Issue Brief*, No. 58, September 1986.

Employee Benefit Research Institute, "Public Policy Options to Expand Health Insurance Coverage among the Nonelderly Population," *EBRI Issue Brief*, No. 67, June 1987.

Freeman, Howard E., *Fact Book: Americans Report on Their Health Care, The 1986 Robert Wood Johnson Foundation Survey*, Institute for Social Science Research, University of California, Los Angeles, May 1987.

Gold, Rachel B. and Asta-Maria Kenney, "Paying for Maternity Care," *Family Planning Perspectives*, 17(3), May-June, 1985.

Hill, Ian T., *Reaching Women Who Need Prenatal Care: Strategies for Improving State Perinatal Programs,* National Governors' Association, Center for Policy Research, Washington, D.C., 1988.

Holohan, J. and J. W. Cohen, *Medicaid: The Trade-off Between Cost Containment and Access to Care*, The Urban Institute Press, Washington, D.C., 1986.

Lewis-Idema, Debra, *Increasing Provider Participation: Strategies for Improving State Perinatal Programs,* National Governors' Association, Center for Policy Research, Washington, D.C., 1988.

National Association of Community Health Centers, Inc., *Community and Migrant Health Centers: Two Decades of Achievement*, Washington, D.C., 1987.

Perloff, Janet D., Phillip R. Kletke, and Kathryn M. Necherman, "Recent Trends in Pediatrician Participation in Medicaid," *Medical Care*, 24(8), August 1988.

The Robert Wood Johnson Foundation, *Special Report: Access to Health Care in the United States, Results of a 1986 Survey*, Special Report No. 2, Princeton, New Jersey, 1987.

Sloan, Frank A., Joseph Valvona, and Ross Mullner, "Identifying the Issues: A Statistical Profile," *Uncompensated Hospital Care: Rights and Responsibilities*, F. A. Sloan, et al., editors, Baltimore, Maryland, 1986.

Southern Regional Project on Infant Mortality, "Study of the AFDC/Medicaid Eligibility Process in the Southern States," Southern Governors' Association and Southern Legislative Conference, Washington, D.C., April 1988.

U.S. General Accounting Office, *Medicaid: Interstate Variations in Benefits and Expenditures*, GAO/HRD-87-67BR, Washington, D.C., May 1987.

U.S. General Accounting Office, Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care, GAO/HRD-87-137, Washington, D.C., September 1987.

U.S. Senate Committee on Labor and Human Resources, "Minimum Health Benefits for All Workers Act of 1988," Committee Report 100-360, Washington, D.C., May 25, 1988.

U.S. Small Business Administration, Office of Advocacy, "Health Care Coverage and Costs in Small and Large Businesses," April 15, 1987.

Wilensky, Gail R. and Kala E. Ladenheim, "The Problem of the Uninsured: Response and Responsibility," a paper presented at the American Public Health Association annual meeting, October 1987.

OBRA-86/87 SUMMARY STATUS
COVERAGE OPTIONS FOR PREGNANT WOMEN AND CHILDREN
AS OF JULY 1988

	ADOPTED/ PERCENT POVERTY	COVERAGE TO AGE 1	≥2	≥5	DROPPED ASSETS TEST	CONTINUOUS ELIGIBILITY	PRESUMPTIVE ELIGIBILITY	EFFECTIVE DATE
ALABAMA	100	X			X	X	X	7/88
ALASKA	100		X		X	X		1/89*
ARIZONA	100			X	X	X		1/88
ARKANSAS	100			X	X	X	X	4/87
CALIFORNIA								
COLORADO								
CONNECTICUT	185	X			X	X		4/88
DELAWARE	100		X		X	X		1/88
DISTRICT OF COLUMBIA	100		X		X	X		4/87
FLORIDA	100			X	X	X	X	10/87
GEORGIA	100		X		X	X		1/89*
HAWAII	100	X			X	X	X	1/89*
IDAHO	67	X			X	UNDECIDED	X	1/89*
ILLINOIS	100	X						7/88
INDIANA	50	X			X	X	X	7/88
IOWA	150		X					1/89*
KANSAS	100		X		X			7/88
KENTUCKY	125		X			X		10/87
LOUISIANA	100			X	X	X	X	1/89*
MAINE	185			X	X		X	10/88*
MARYLAND	100		X		X	X	X	7/87
MASSACHUSETTS	185			X	X	X	X	7/87
MICHIGAN	185		X		X	X		1/88
MINNESOTA	185	X			X	X		7/88
MISSISSIPPI	185		X			X		10/87
MISSOURI	100		X			X		1/88
MONTANA								
NEBRASKA	100		X		X	X	X	7/88
NEVADA								
NEW HAMPSHIRE								
NEW JERSEY	100		X		X	X	X	7/87
NEW MEXICO	100		X			X	X	1/88
NEW YORK							X	UNDECIDED
NORTH CAROLINA	100		X		X	X	X	10/87
NORTH DAKOTA								
OHIO	100	X			X	X		1/89*
OKLAHOMA	100		X		X	X		1/88
OREGON	85/100[1]		X		X	X		11/87
PENNSYLVANIA	100		X		X		X	4/88
RHODE ISLAND	100		X		X	X		4/87
SOUTH CAROLINA	100	X			X	X		10/87
SOUTH DAKOTA	100	X			X	X		7/88
TENNESSEE	100			X	X	X		7/87
TEXAS	100		X			X	X	9/88*
UTAH	100		X		X	X	X	1/89*
VERMONT	185			X		X		10/87
VIRGINIA	100	X			X	X		7/88
WASHINGTON	90		X			X		7/87
WEST VIRGINIA	150			X	X	X		7/87
WISCONSIN							X	4/88
WYOMING	100	X			X	X		10/88*
TOTAL	43	12	22	9	34	37	19	

[1] This state will increase their income thresholds to 100% of poverty during 1988.

* Projected Implementation Date

SOURCE: National Governors' Association, 1988

TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

A Summary

- The Maternal and Child Health and Crippled Children's Services Grant was enacted in 1935 as Title V of the Social Security Act. The impetus for this legislation dates to the early 1900s and actions such as the formation of the Children's Bureau and the passage of the Sheppard-Towner Act.

- The goal of Title V has always been to promote the health of all mothers and children, especially those at risk for poor health.

- Originally, Title V included a series of programs. Since 1981, it has been a block grant, meaning that the formerly separate categorical programs are now funded as one package to the states.

- States match the federal funds: for every 4 federal dollars received, each state contributes 3 dollars. In general, most of the block grant funds (85 percent) are distributed to states on the basis of the amount the states received under the categorical programs and on the proportion of low-income children in the state compared to the national average. Fifteen percent of the total is set aside at the federal level to be used for special projects of regional and national significance (SPRANS).

- The overall appropriation level of the block grant increased from $373 million in fiscal year 1982 to $527 million in fiscal year 1988. However, viewed in constant dollars, there has been a net loss in purchasing power since the mid 1970s.

- States have considerable flexibility within the block of funds to support those programs for which the state has greatest need. Over half the states have generated additional funds from state sources to meet the level of funding needed: the additional annual amounts range from $100,000 to $18 million per state.

- The block grant in many states can be credited for state leadership and strategies to reduce infant mortality by conducting needs assessments, developing service systems and standards, coordinating services, and sometimes, directly providing health care services to those in need.

- Title V's ability to take the lead in assuring the delivery of comprehensive, high quality services to pregnant women and children has been hampered by the multiplicity of programs serving the health needs of mothers and children. The result has been fragmentation of efforts among several federal and state agencies administering these programs and the services themselves.

- Inadequate funding is a major impediment to Title V's ability to achieve its goals. State programs are finding it even more difficult to maintain existing--much less expanding--levels of activities and services or to plan new initiatives in the face of unpredictable and insufficient funding.

TITLE V MATERNAL AND CHILD HEALTH SERVICES BLOCK GRANT

In 1935, the United States had one of the highest maternal mortality rates among industrialized nations and 1 of every 100 children was born handicapped with only a very small proportion receiving timely treatment. Concerned over these facts, the Congress in 1935 enacted Title V of the Social Security Act, creating Maternal and Child Health and Crippled Children's Services, with the goal of ensuring the health of all mothers and children, particularly those in rural areas and suffering from economic distress.

Title V monies generally were allocated to the states which then determined how the money would be spent. States matched the federal allotment with their own funds. Few major changes were made to the Title V program between 1935 and the early 1980s except for increased funding levels. Funds were distributed for projects on the state level through formula grants with the majority of funds being allotted to states for maternal and child health and crippled children's services. The states then determined what services were needed, provided they included at least one program in each of the following areas: maternity and infant care, children and youth, family planning, dental health, and intensive infant care. These were referred to as a "program of projects."

In 1981, Title V was amended to establish a "block grant." This means that funds for programs related to maternal and child health concerns would be allocated to states as one package. Generally, the purpose of the block grant remained the same as those of the previous categorical programs that were consolidated into the block: to enable each state to assure all mothers and children access to quality health services, reduce infant mortality, prevent diseases and handicapping conditions among children, and provide rehabilitation services for crippled children. The block grant consolidated the following categorical programs:

- The Maternal and Child Health Program: includes prenatal clinics, maternity nursing services, well-child conferences, immunization programs, school health programs, the Maternity and Infant Care program, and various screening programs.
- The Crippled Children's Program: includes early identification of crippled children; prevention, diagnostic and treatment services; training of personnel; and administrative concerns.
- The Supplemental Security Income Services for the Disabled Program.
- The Lead-Based Paint Poisoning Prevention Program.
- The Genetic Disease Testing and Counseling Program.
- The Sudden Infant Death Syndrome Program.
- The Hemophilia Program.
- The Adolescent Pregnancy Program.

GOALS OF THE BLOCK GRANT

The goals of the Title V Block Grant are purposefully very broad:

- "To assure mothers and children (particularly those with low incomes or with limited availability of health services) access to quality maternal and child health services,

- "To reduce infant mortality and the incidence of preventable diseases and handicapping conditions among children and,

- "Otherwise to promote the health of mothers and children especially by providing preventive and primary care services for low-income children, and prenatal, delivery, and postpartum care for low-income mothers."

WHO THE BLOCK GRANT SERVES

Title V does not include clearly defined eligibility criteria. One of the goals of the program is to assure (not necessarily provide) all women and children access to preventive health services. The lack of universal financial access to preventive health services, particularly prenatal care, however, leaves state maternal and child health

110

programs unable to adequately meet this broad goal. Programs, as a result, tend to be targeted to those most at risk. The Department of Health and Human Services does not collect national data in a uniform manner that would provide the number of women and children served and the services provided.

According to a 1986 survey by The Alan Guttmacher Institute, of Title V agencies in 47 states, 436,000 women received prenatal care that was either directly provided by or financed through Title V. Income eligibility for services varied from state to state, but the women were predominantly poor or near-poor: 64 percent were uninsured, 27 percent were covered by Medicaid, and 9 percent had private health insurance.

FUNDING

Federal funds are distributed to the states on the basis of the amount each state received under the categorical programs prior to 1981 and the proportion of low-income women and children in the state. States contribute 3 state dollars to its maternal and child health programs for every 4 federal block grant dollars received.

Prior to the passage of the 1986 amendments to Title V (OBRA-86, P.L.99-509), 85 percent of the total block grant funds was distributed to the states each year and 15 percent was retained by the Department of Health and Human Services for special projects of regional and national significance (SPRANS). SPRANS grants fund demonstration projects and assist in data analysis and training of personnel, among other things. According to the Bureau of Maternal and Child Health and Resources Development, in 1987, 45 percent ($31 million) of all SPRANS projects focused on infant mortality and low birthweight reduction efforts.

The 1986 amendments changed the distribution somewhat, earmarking portions of both the federal and state shares of any total block grant amount above $478 million (the total block grant appropriation for fiscal year 1985) to promote children's access to primary health care services and to community-based and case-managed services for children with special health care needs.

Some argue that the distribution formula used by the federal government results in an inequitable allocation of funds among the states. The General Accounting Office is currently evaluating an alternative formula and will assist the Congress in selecting a formula that will provide a more equitable distribution of funds to the states.

States have considerable flexibility within the block grant to fund those programs for which the state has the greatest need. In general, Title V does not clearly define how funds can and cannot be used. For example, Title V is intended to promote, not necessarily provide, prenatal, delivery, and postpartum care for low-income mothers. The law specifically states that funds cannot be used for inpatient services, other than those provided to crippled children, high-risk pregnant women and infants, and others that the Secretary of the Department of Health and Human Services expressly approves. The purpose of this restriction is to ensure that states do not substantially increase their use of funds for in-hospital care as opposed to funds directed toward prevention and primary care. States have the flexibility however, to define "high-risk" women as those who have no health insurance, thus providing them with needed hospital delivery services.

Such flexibility allows for the tailoring of programs to meet state needs. In states with high numbers of women without financial access to basic health care services, such as prenatal care, the priority for Title V funds may be to remove financial barriers and assure the availability of services. In other states where access problems are not so overwhelming, Title V funds may more often be used to fulfill broader goals: conducting population needs assessments, facilitating better coordination between programs, and assisting in the development of models and standards of care.

States have expressed concern that the level of federal funding is too low. The fiscal year 1982 funding level, the first year after the consolidation of the categorical programs into the block grant, represented an 18 percent reduction in funds from the total level for the categorical programs, a reduction that has not been made up in real dollars.

Many states have allocated additional monies to increase their state program funding levels. According to a 1987 study by The Alan Guttmacher Institute, 47 states supplement their federal funds with additional state funds above the required state match, with the amounts ranging from $100,000 to $18 million per state. The additional monies are used for a variety of special projects, such as targeting hospital care for pregnant women and services for high-risk groups such as teenagers.

ADMINISTRATION OF THE BLOCK GRANT

The Bureau of Maternal and Child Health and Resources Development within the Department of Health and Human Services is responsible for Title V funds at the federal level. The program, however, is considered a state-administered program. The original objective of the block grant, in keeping with the "new federalism" philosophy of the Reagan Administration, was to provide states with more authority to determine their own needs and establish funding priorities within the block to meet those needs. The opportunity for states to determine funding patterns and priorities and meet state needs has been tempered by the reduced purchasing power of federal funding for the block grant.

REPORTING REQUIREMENTS

The federal law establishing the block grant and the subsequent regulations provide for very few enforceable reporting requirements. States are required to submit reports of intended Title V activities and expenditures with a description of program activities and a record of the purpose of these activities, and the extent to which the funds are expended according to the state plan. States are also required to conduct independent audits of expenditures.

The federal government does not require a particular uniform format for reporting this program information. Although the basis for the reporting requirement exists in the law, no uniform, national data are available for an analysis of the program's effectiveness and efficiency. Without enforceable reporting requirements, the data base will most likely not improve.

PROGRAM FUNCTIONS

State Title V programs have limited resources, broad mandates, many areas of uncertainty in the actual meaning and mandate of the law, and few enforced reporting requirements. While all states are carrying out some of the roles defined below, few, if any, are effectively meeting all of them. Program functions include:

- Conducting assessments of state needs: Title V programs are expected to identify within each state the groups of women and infants most at risk for morbidity or mortality. The programs are to monitor progress made in the health status of these groups.

- Coalescing state leadership and state strategies: State Title V agencies are required to develop state plans and many are taking a lead role in convening special task forces and commissions to examine the health problems in their state.

- Developing service systems: Title V agencies have been responsible for working with health care providers and hospitals to develop and set standards for new systems, such as the regionalization of maternal and child health services, for providing care.

- Developing and monitoring standards of care: Title V agencies have developed systems of care and are monitoring the progress of these systems and assisting in establishing procedures for identifying the at-risk populations and determining which providers are qualified to care for these groups.

- Coordinating services at the state level: Title V agencies are working to coordinate the array of state programs that serve pregnant women and children to ensure the availability and accessibility of comprehensive health care and social services.

- Providing services, directly and/or indirectly: the dollars appropriated to Title V programs have not allowed them to fully subsidize all of the services needed by mothers and children that are otherwise unavailable or inadequately financed; however, many states are increasing the amount of program monies targeted to directly pay for care.

- Providing technical assistance and training: as part of a comprehensive strategy to prevent infant mortality, Title V agencies are involved in developing educational materials and curricula, media campaigns, and other initiatives to reach at-risk groups, communities, and health professionals.

ISSUES CONCERNING THE TITLE V PROGRAM

Title V has been credited with assisting in the decline in infant mortality nationally, in some states more directly than in others. Many agree that an entity at the state level is needed to oversee the variety of efforts on behalf of the health of women and children; however, the program has met with criticism that, in light of its broad mandate and long history of funding and activities, it does not more effectively and efficiently promote maternal and child health and specifically reduce infant mortality. Numerous factors affect the ability of the Title V program to accomplish its broad mandate.

Fragmentation of Efforts

The multiplicity of programs serving the health needs of mothers and children, the fragmentation of efforts among several federal and state agencies administering these programs, and the lack of effective coordination among them have served as impediments to Title V's ability to assure that pregnant women and children receive comprehensive, high-quality services. The block grant was meant to facilitate planning on a state level and an increased ability to meet the needs of women and children in that state. Many state Title V programs have been successful in reducing the fragmentation, but the task is enormous.

Many state Title V agencies have difficulty in attempting to take the lead role in coordinating services for mothers and children with larger programs such as Medicaid, the main public health financing program for low-income persons, and the Special Supplemental Food Program for Women, Infants, and Children (WIC). This can be synonymous with sending a mouse to do a lion's job. Medicaid expenditures for fiscal year 1987 were $50.0 billion compared to WIC expenditures of $1.8 billion for fiscal year 1988 and MCH Block Grant expenditures of $527 million for fiscal year 1988. The relative weight of Title V is clear. Experience shows that a more direct incentive is needed for Medicaid, WIC, and the Title V agencies to actually create and carry out these cooperative agreements.

Lack of Accountability

States are required to submit yearly Reports of Intended Expenditures to the Secretary of Health and Human Services that describe how the block grant funds will be used. Because of the minimal federal role under the block grant in setting standards, delineating reporting requirements, and providing technical assistance to the states, national-level information on state activities, populations served, and other data is rather general and not uniform. Although the flexibility provided by the block grant has been important in helping states meet their specific needs, some have argued that states need to be held accountable for developing well-conceived plans and documenting their progress toward achieving goals. This is problematic without a strengthened statutory base and increased support and oversight at the federal level.

Inadequate Funding

Inadequate funding has been cited as a major impediment to ensuring the health of mothers and children. The overall appropriation level of the block grant increased from $373 million in fiscal year 1982 to $527 million in fiscal year 1988. In constant dollars, however, there has been a net loss in purchasing power since the mid-1970s. Title V programs are having more difficulty maintaining their existence, much less expanding levels of activities and services or planning new initiatives in the face of unpredictable and inadequate funding.

CONCLUSION

The goal of the Title V Maternal and Child Health Program, enacted in 1935, has always been to assure access to health related services for mothers and children, especially those with low incomes or of poor health. Originally, Title V was funded as several grants, including Maternal and Child and Crippled Children's Services. Since 1981, it has become a block grant, meaning that previously categorical programs are now funded as one package. State block grants are funded with federal and state (and sometimes local) monies.

The block grant in many states can be credited for state leadership and effective strategies in conducting needs assessments, developing service systems and standards, coordinating services and, where necessary, directly providing health care services to those in need. Concerns with the program include its inability to better address the problem of fragmented services for mothers and children, state programs' lack of accountability, and continued inadequate funding.

REFERENCES

The Alan Guttmacher Institute, *Blessed Events and the Bottom Line: Financing Maternity Care in the United States,* New York, 1987.

The Alan Guttmacher Institute, *The Financing of Maternity Care in the United States,* New York, December 1987.

Bailey, Susan, *The Maternal and Child Health Services Block Grant, Title V of the Social Security Act*, U.S. Library of Congress, Congressional Research Service, 83-93EPW, Washington, D.C., May 5, 1983.

U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, *Improving MCH/WIC Coordination*, HHS-100-84-0069, Washington, D.C., August 1986.

U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Improving MCH/WIC Coordination: A Final Report and Guide to Good Practices,* Washington, D.C., 1986.

U.S. General Accounting Office, *Maternal and Child Health Block Grant: Program Changes Emerging Under State Administration,* HRD-84-35, May 7, 1984.

U.S. General Accounting Office, *Prenatal Care, Medicaid Recipients and Uninsured Women Obtain Insufficient Care,* GAO/HRD-87-137, Washington, D.C., September 1987.

COMMUNITY AND MIGRANT HEALTH CENTERS

COMMUNITY AND MIGRANT HEALTH CENTERS

A Summary

- Nearly six million low-income and medically underserved individuals receive primary health care each year through federally-supported Community and Migrant Health Centers.

- Over 2,000 health care sites, run by approximately 600 public and private non-profit entities, provide comprehensive primary care to the target population in all states except Wyoming and in Puerto Rico and the District of Columbia.

- The programs provide high quality health care for those people most likely to lack access to health services due to geographic isolation, lack of providers, or limited financial resources.

- Nearly 70 percent of patients are members of minority groups; over one in three is black and nearly one in three is Hispanic. American Indians, Asians, and Indochinese and Haitian refugees also rely on the Health Centers.

- 1.3 million patients are women of childbearing age, and 2.1 million are children under age 15.

- In 1986, Health Center patients accounted for nearly 120,000 births--3.2 percent of all births nationwide and 6.4 percent of low-income births.

- Nearly 60 percent of Health Center patients have no health insurance; 25 percent are covered by Medicaid.

- Community and Migrant Health Centers are sound investments, proven to reduce infant mortality, promote the use of preventive care, reduce reliance on inappropriate emergency room usage, and respond to public health issues such as health care for the homeless.

- Health Centers have been found to account for 12 percent of the decline in the black infant mortality rate that occurred in the United States between 1970 and 1978. Counties served by Health Centers have been found to have black infant mortality rates 2.9 per 1,000 deaths lower, and white infant mortality rates 1.5 per 1,000 deaths lower, than surrounding counties.

- A new $20-million federal infant mortality reduction initiative emphasizes the important role of Community and Migrant Health Centers in improving the health status of mothers and children.

- A sharply declining supply of National Health Service Corps physicians and a dwindling supply of community physicians providing obstetrical care, especially for low-income women, have seriously affected many Centers' ability to either furnish or arrange for delivery services to their prenatal patients.

COMMUNITY AND MIGRANT HEALTH CENTERS

Through the federally supported program of Community and Migrant Health Centers, significant contributions have been made to increase access to quality health care for low-income and uninsured families. Begun in 1965 as eight research and demonstration projects, the programs have expanded over the past 20 years into over 2,000 health care sites providing comprehensive primary care to nearly six million poor and medically underserved Americans in all states except Wyoming and in Puerto Rico and the District of Columbia.

The purpose of the Health Centers is to provide high quality preventive health care for those people most likely to lack access to health services because of geographic isolation, lack of providers, or lack of financial resources. In general, the Health Centers provide basic primary medical care, such as physician and nurse midwife services; preventive health services and dental care; and ancillary services, such as laboratory tests, x-rays, and prescription drugs.

Community and Migrant Health Centers have proven to be sound investments. Studies have demonstrated that the centers reduce the incidence of infant mortality, promote the use of preventive health care, reduce reliance on emergency room care, and respond to public health issues, such as health care for the homeless.

Despite the large numbers of persons cared for by Community and Migrant Health Centers, less than one fourth of America's medically underserved residents are reached by these services. Furthermore, provision of care is increasingly jeopardized by a sharply declining supply of National Health Service Corps physicians and a dwindling supply of community physicians providing obstetrical care, especially for low-income women, with whom the Health Centers can contract for hospital delivery of women who received prenatal care through the Health Centers.

OVERVIEW

Community Health Centers, authorized under Section 330 of the Public Health Service Act, are an important source of primary care for medically underserved, disadvantaged populations. They are in areas throughout the country where financial and/or geographic barriers to primary health care affect a substantial part of the population.

Approximately 600 public and private non-profit Health Centers receive federal grants through the Community and Migrant Health Center programs. Of these grantees, about 60 percent are located in rural areas of the country, with the remaining in high-poverty urban areas.

Approximately six million individuals receive services annually. About 60 percent have incomes below the federal poverty level and 35 percent have incomes between 100 percent and 200 percent of the poverty level.

Migrant Health Centers, authorized under Section 329 of the Public Health Service Act, provide primary health care to migrant and seasonal farmworkers [1] and their families.

The 122 Migrant Health Centers operate about 378 clinic sites in over 300 rural areas in 35 states and Puerto Rico. These Centers serve more than 450,000 migrant and seasonal farmworkers, which represent about 15 percent of the estimated migrant and seasonal farmworker population of three million.

About 70 Health Centers are jointly funded as Community and Migrant Health Centers operating in the same community.

Administration and funding

The U.S. Department of Health and Human Services (HHS), Bureau of Health Care Delivery and Assistance, is responsible for the community and migrant Health Center program, with 10 regional offices responsible for day-to-day administration and oversight. The centers themselves are governed by representatives of the communities they serve.

Recent federal appropriation levels for Community and Migrant Health Centers have increased from about $393 million in 1984 to about $426.5 million in 1988, as shown in table 1. The Office of Technology Assessment recently reported, however, that in constant 1978 dollars,

Table 1
Federal Appropriations for Health Centers

Fiscal year	Community	Migrant
	(in millions)	
1984	$351.35	$42.0
1985	360.0	44.3
1986	396.0	45.4
1987	400.0	45.4
1988 [a]	382.96	43.5
1988 Infant mortality initiative	19.148	.957

[a] *For fiscal year 1988, all domestic discretionary programs, which includes many health programs, were decreased 4.26 percent in accordance with the Budget Summit agreement reached by the executive and legislative branches in November 1987.*

funding levels had fallen from $259.5 million in 1978 to $223.4 million in 1986.

In fiscal year 1988, the Congress appropriated about $20 million for the Health Center programs for a new competitive grant program as part of HHS's infant mortality reduction initiative. The Congress targeted this funding to emphasize the importance of providing, through these Health Centers, improved and expanded maternal, infant, and child health services designed to reduce infant mortality.

Medical services provided are not funded solely through the federal community and migrant health center programs, although they make up almost half of total revenues. In calendar year 1987, federal grants through the community and migrant health center programs constituted 45 percent of their annual revenues. Among other revenue sources were federal Maternal and Child Health block grant, family planning, and WIC grants (3 percent); Medicaid (15 percent); Medicare (6 percent); patient collections (10 percent); and state, local and other (12 percent).

Community and Migrant Health Center expenditures for administrative and overhead costs cannot exceed 16 percent of revenues. These costs are defined to include all facility costs such as leases and mortgages, utilities and telephone, maintenance, and managerial staff. While the national average for Health Centers' administrative and overhead costs are 13 percent to 14 percent of revenues, some do exceed 16 percent; federal waivers are needed in such cases.

Health Centers have historically been established through community initiative, which involved identifying the need, determining a locus of responsibility to establish and manage the Health Center, and pinpointing available funding sources. In recent years, HHS and states have worked together on primary care needs assessments and planning for states, counties, and communities to identify areas of unmet need and help establish Health Center facilities.

As might be expected, the type and extent of community coordination of medical and social services for persons in need varies from community to community. Recognizing that the need for services generally far exceeds the supply, state and local governments and community groups attempt to coordinate their programs. For example, 28 of the 32 Community Health Centers in Texas are certified WIC providers. In many urban and rural areas, Health Centers form consortia to take advantage of bulk purchase discounts and shared services, such as laboratory services, which might otherwise be cost prohibitive. While there may be some overlap between Community and Migrant Health Centers and state and local health departments in offering prenatal and postpartum care, efforts are generally made to coordinate.

Individuals served

The Community and Migrant Health Center programs operate a total of 2,000 clinic sites serving nearly six million patients. According to the National Association of Community Health Centers,

- 1.3 million of these patients are women of childbearing age, and 2.1 million are children under the age of 15.
- In 1986, Health Center patients accounted for nearly 120,000 births--3.2 percent of all births nationally and 6.4 percent of all low-income births.
- Virtually all patients are poor or near poor; only 6 percent have incomes over 200 percent of the federal poverty level.

- Nearly 60 percent are completely uninsured; 25 percent are covered by Medicaid.

- Nearly 70 percent are members of minority groups, who typically suffer disadvantages in both their health status and in access to health care. Over one in three patients is black; nearly one in three is Hispanic. Other minorities who depend on Health Centers include American Indians, Asians, and Indochinese and Haitian refugees.

Cost of services to patients

According to program regulations, care must be free for individuals and families with incomes at or below the federal poverty level, while individuals and families with incomes above 200 percent of poverty are required to pay the full fee. Local projects, however, have the flexibility to collect nominal fees even from persons below the poverty level when that is consistent with the individual project's goals.

A recent survey of Community and Migrant Health Centers conducted by The Alan Guttmacher Institute found that the median fee for a woman receiving prenatal care in 1986 was $6.50 for an initial visit and $5.00 for each subsequent visit, $82 for a prenatal and postnatal care package, and $199 for a prenatal and postnatal care and delivery package.

HEALTH CENTERS' PROVEN EFFECTIVENESS

A number of independent and federally funded studies have found that Community and Migrant Health Centers are enormously effective in delivering preventive health care, especially maternity and pediatric care, to high-risk populations. Health Centers have been found to promote the use of preventive health care, reduce reliance on emergency rooms for nonacute care, and reduce the incidence of infant mortality.

- 40 percent of all Health Center visits are for preventive and health maintenance care, and a greater percentage of patients receive routine physical exams than comparable community residents not using Health Centers.

- Community Health Center patients receive more prenatal care, and show 52 percent higher immunization rates and 20 percent higher pap smear rates than comparable community residents.

Major reductions in infant mortality--as much as 40 percent--have been achieved in areas served by Health Centers because of the access they provide to high quality maternity and infant care services.

- Health Centers alone have been found to account for 12 percent of the decline in mortality rates among black infants that occurred in the United States between 1970 and 1978.

- Counties with four or more Health Centers have infant mortality rates as much as 10 percent lower than counties with no Health Centers.

- Counties served by Health Centers have been found to have black infant mortality rates that were 2.9 per 1,000 deaths lower, and white infant mortality rates that were 1.5 per 1,000 deaths lower, than surrounding counties.

Because of the emphasis on preventive care in a clinic setting, Health Center patients have lower utilization rates for more costly emergency room visits and reduced hospital use and costs, well below rates of individuals served by other providers.

- Reductions in emergency room use have ranged from 13 percent to 38 percent in the case of pediatric emergency room use.

- Centers have reduced hospital admission rates by anywhere from 22 percent to 67 percent. They have also reduced the number of patients admitted per year and the length of stay among those patients who are admitted. One study showed that Health Center patients have a 25-percent lower hospitalization rate than other patients.

- Community Health Centers have been shown to reduce by 40 percent Medicaid payments per person per year. Hospitalization rates have been cut by 44 percent, hospital days per year per patient by 62 percent, and average length of stay by 34 percent.

- One study, completed in November 1981, showed that total Medicaid savings in one year alone amounted to $580 million, $219 million more than the 1980 appropriation for Community Health Centers. Each dollar spent on the community Health Center program saved $1.61 in reduced Medicaid expenditures.

MATERNITY SERVICES PROVIDED

The authorizing legislation defines the primary health services that must by provided by the Health Centers as including perinatal services. HHS regulations specify that this means prenatal and postpartum care. Other services relevant to maternity care that must be provided are physician services, laboratory and pharmaceutical services, and transportation. Hospital services are considered "supplemental health services" that may be provided when necessary for the adequate support of the primary health services.

Although payment for hospital services is permitted under the Migrant Health program, HHS policy does not permit such payment by Community Health Centers. However, they are required by law to develop an ongoing referral relationship with at least one hospital. The patient is responsible for hospital costs, either through public or private insurance or private resources. Because the majority of Health Center patients are uninsured, hospitals often have to write off these costs as bad debt.

HHS standards further stipulate that all agencies either provide or arrange for prenatal and delivery services. Formal linkages with appropriate level hospitals are required. HHS has prepared guidelines on perinatal care for the Health Centers emphasizing comprehensive care, linkage with a hospital for delivery, and adequate care for high-risk patients. Reality, however, often differs from requirements, as discussed under "areas of concern."

Despite studies that have shown the general effectiveness of Community and Migrant Health Centers, there is no national data on the provision of maternity services through the centers. Since HHS does not require that data on the provision of maternity care be collected and reported, little is known about the extent to which such care is actually provided. Even the precise number of women receiving prenatal care is unknown. Two recent surveys estimated that the number of women receiving prenatal care through the Health Centers ranged from 120,000 to 213,000 in 1986.

To help fill this information gap, The Alan Guttmacher Institute recently conducted a survey of Community and Migrant Health Centers to ascertain the extent to which they provide maternity care, the characteristics of the population served, and the kinds of services provided. Thirty-six percent of the agencies responded, constituting a representative sample of all such Centers according to region, urban or rural location, and agency type (community or migrant).

In general, The Alan Guttmacher Institute found that, in 1986:

- About 4 percent of all patients served by the responding agencies were prenatal patients.
- 85 percent of the responding agencies provided prenatal care, serving about 76,700 patients. From this it was projected that all federally funded Health Centers served about 213,000 prenatal patients.[2]
- Thirty-four percent of agencies that provided prenatal care did not serve high-risk patients on site, largely because they are unable to recruit appropriate providers or contract with obstetrical personnel to provide such care. Frequently, however, Health Centers serving only low-risk patients offer paid referrals for high-risk patients to others for appropriate care.
- Characteristics of the prenatal care patients served included:

Income: 64 percent were below federal poverty; 24 percent between 100 percent and 200 percent; and 12 percent above 200 percent of poverty.

Insurance: 44 percent were covered by Medicaid; 42 percent were uninsured; 14 percent had private insurance.

Age: 27 percent were teenagers; 65 percent aged 20 to 34; 8 percent aged 35 or older.

- Prenatal care patients made an average of 7 visits each. Of these, 48 percent entered care in the first trimester; 38 percent in the second trimester; and 14 percent in the third.[3]

- Some prenatal care services were not directly provided by some Health Centers on site: 24 percent did not provide Rho-gam shots; 52 percent did not provide ultrasound; 69 percent did not provide fetal oxytocin stress tests; 59 percent did not provide nonstress tests; and 70 percent did not provide amniocentesis.[4] While the Health Centers often refer patients to others for appropriate care, finding referral physicians to conduct special tests was a problem encountered by a number of Health Centers.

- 16 percent of the agencies that provided prenatal care paid some or all of the hospital bill for delivery for 2,700 women. It is projected that all federally-funded Health Centers helped pay for about 7,500 deliveries.

- Whether or not agencies helped pay for hospital delivery, their staff or contracted personnel attended 49 percent of deliveries.

INFANT MORTALITY INITIATIVE

In fiscal year 1988, the Congress appropriated to HHS $19,148,000 for Community Health Centers and $957,000 for Migrant Health Centers to undertake a Comprehensive Perinatal Care program, to emphasize the need to provide improved and expanded maternal, infant, and child health services designed to reduce infant mortality. The specific goals of the legislative initiative are to

- improve pregnant women's and children's access to needed health services;

- enhance the ability of the Health Centers to provide comprehensive perinatal ambulatory care services;

- enrich the Centers' services by adding staff for outreach, health care, nutrition education, etc.;

- better coordinate services between the Health Centers and other local public and private providers of medical, health, and health-related services;

- increase the number of nurse practitioners and certified nurse midwives at the Health Centers and underserved areas and at Indian Health Service and Native Hawaiian Center sites; and

- expand educational programs for medical and health personnel in order to improve their ability to deliver maternal and child health services.

In order to implement this infant mortality initiative, HHS plans to award supplemental grants to existing Community and Migrant Health Centers to develop and expand perinatal systems designed to reduce low birthweight, enhance the provision of primary and supplemental health services, and improve access to needed services for pregnant women and children. It is anticipated that about 125 to 175 projects will be funded in fiscal year 1988.

AREAS OF CONCERN FOR COMMUNITY AND MIGRANT HEALTH CENTERS

Primary concerns impeding the Health Centers' capability to provide optimum care include uncertain physician supply and an inability to ensure continuity of care for women from prenatal care through hospital delivery. Increasingly, the Health Centers are finding it difficult to contract with community providers to provide hospital delivery for women who received prenatal care through the Health Centers. Problems in recruiting and retaining physicians and mid-level providers, such as certified nurse midwives, are exacerbated by:

- Soaring medical malpractice insurance costs, estimated to be approximately $40 million for Community and Migrant Health Centers, up from about $10 million in the mid 1980s. Such costs consume resources that might otherwise be spent on direct care and discourage physicians from undertaking medically high-risk cases. One Community Health Center in Texas experienced a malpractice insurance premium increase from $21,000 to $220,000 in one year, with no history of malpractice suits and no such threats.

- Dwindling federal resources devoted to the National Health Service Corps program which has been an important source of physicians.

The 1,800 National Health Service Corps physicians serving Community and Migrant Health Centers constitute 50 percent to 60 percent of their total physician strength. With the phasing out of the Corps program, in part because of a reported overall increase in the national physician supply, Health Centers face an imminent provider crisis. To this end, both short-term and long-term recruitment and retention efforts are being used to attract and retain providers, including working with medical residency programs to rotate residents through the Health Centers; working with medical school faculties to establish relationships with Health Center providers; and improving compensation packages such as increased salaries and benefits, repaying medical school loans, providing continuing medical education; and improving hospital admission privileges, especially for family practitioners and certified nurse midwives.

Health Centers' linkages with the hospital appear to be the weakest link in their maternity care chain. Many Health Centers are unable to help their patients gain hospital admission because patients are often uninsured and do not have the personal resources to pay for their hospital care. Hospitals often require a substantial preadmission downpayment, usually from $500 to $1,000, which the average patient is unable to pay. Many Health Centers report that at least some of their patients are admitted through hospital emergency rooms for their delivery. Hospitals are then left with substantial uncompensated care costs.

The solution to this problem is not an easy one. Expending Health Center funds on hospital delivery services would quickly exhaust resources and would no doubt significantly reduce the number of women who could obtain prenatal care. This issue--uncompensated care--is one not just for the Community and Migrant Health Center programs, but rather a major health financing issue for all states and the nation.

CONCLUSION

Community and Migrant Health Centers play a significant role in providing primary health care, especially maternity care, to low-income and medically underserved individuals. Proven to be a cost-effective source of care, they serve significant numbers of this target population.

However, at current funding levels, the Health Centers are estimated to reach only one-fourth of the people who need care: individuals unable to obtain health services otherwise due to geographic isolation, lack of providers, or lack of financial resources. Furthermore, the Health Centers are experiencing difficulties in bringing women into the system for early prenatal care and an adequate number of visits. They also have limited capability for serving high-risk patients and meeting the needs of some women who may need special tests or procedures. The capability to deliver services is also hampered by uncertain physician supply and an inability to ensure continuity of care through hospital delivery.

Recognizing the potential of Community and Migrant Health Centers to help alleviate the problem of infant mortality, the Congress has targeted new monies specifically for this purpose. Such an initiative is an important recognition of their special role and potential in improving the overall health status of this special population.

NOTES

1. A migrant or seasonal farmworker is an individual whose principal employment within the last 24 months is in agriculture on a seasonal basis. The only difference between a migrant and a seasonal farmworker is the migrant travels and establishes a temporary abode for employment purposes. Some migrants travel a few hundred miles, while others may travel more than a thousand miles as they follow crops north in the spring and return south in the fall. Access to care for migrants is therefore difficult to achieve because of their lifestyle, language and cultural differences, and economic status. In addition, most states consider migrants temporary residents, thus rendering them ineligible for Medicaid.

2. This contrasts with a randomized survey of 110 Community and Migrant Health Centers conducted by the National Association of Community Health Centers which concluded that 120,000 women were given prenatal care in 1986 and 62,000 were delivered by Health Center providers.

3. A recent General Accounting Office study of Medicaid recipients and uninsured women found that 42 percent of the women they surveyed with uncomplicated pregnancies began care in the first trimester and received an average of nine prenatal visits. The American College of Obstetricians and Gynecologists recommends that prenatal

care begin in the first trimester of pregnancy and consist of 13 visits for a normal 40-week pregnancy.

4. When a pregnant woman is found to be RH negative, one or more **Rho-gam shots** are indicated to prevent the formation of antibodies against the fetus that can lead to miscarriage or stillbirth. An **ultrasound** examination may be required at certain times during the pregnancy to determine fetal position or identify certain defects. A **fetal oxytocin stress test** is performed to assess the condition of the fetus under the stress of uterine contractions that are brought about by adminstering oxytocin. **Nonstress testing** is a form of fetal monitoring in which electrodes monitor fetal movement and heart rate. **Amniocentesis** entails the withdrawal of a sample of amniotic fluid for laboratory analysis. Performed in the second trimester of pregnancy, analysis can reveal one of well over 200 genetic disorders in the fetus, enabling the women to terminate the pregnancy or prepare for the birth of a sick infant.

REFERENCES

The Alan Guttmacher Institute, *The Financing of Maternity Care in the United States,* New York, December 1987, pp. 239-48.

National Association of Community Health Centers, Inc., *Community and Migrant Health Centers: Two Decades of Achievement,* Washington, D.C., 1987.

National Clearinghouse for Primary Care Information, *Community Health Centers: A Quality System for the Changing Health Care Market,* McLean, Virginia, Fall 1986.

U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future*, OTA-H-345, Washington, D.C., February 1988.

U.S. Department of Health and Human Services, Health Resources and Services Administration, Bureau of Health Care Delivery and Assistance, factsheets, "Primary Care: Program Overview," "Primary Care: Community Health Center Program," and "Primary Care: Migrant Health Center Program."

U.S. General Accounting Office, *Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care,* GAO/HRD-87-137, September 1987.

U.S. Senate, Committee on Labor and Human Resources, "Public Health Service Act Infant Mortality Amendments of 1987," Report 100-137, August 3, 1987.

THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS, AND CHILDREN (WIC)

A Summary

- The Special Supplemental Food Program for Women, Infants, and Children (WIC) provides nutritious foods, nutrition education, and increased access to medical care to low-income, high-risk women and children under 5 years of age.

- Funds for WIC are appropriated by the Congress and administered by the United States Department of Agriculture (USDA). The fiscal year 1988 funding for WIC is $1.8 billion and serves 3.4 million women and children. This is an impressive number, but only about 2 in 5 of the 7.5 million who qualify for the program are served.

- The funds are awarded to state health departments and then distributed to local clinics and community agencies.

- Women and children who meet certain financial or nutritional risk qualifications are eligible to receive vouchers to be used to purchase specified foods low-income families may be lacking, such as protein, iron, calcium, and vitamins A and C.

- WIC has been enormously successful and has been shown to increase the likelihood of a healthy birth.

- The benefits are more than nutritional because high-risk mothers are encouraged to seek health services, including both prenatal and postnatal care.

- WIC has been proven to be cost-effective. For every $1 spent through WIC, up to $3 can be saved in medical care.

- Several states are taking steps to increase their ability to reach and serve those in need. Action steps include supplementing federal funds with state funds, offering incentives to health care providers to care for WIC recipients, and developing automatic referral mechanisms between WIC and Medicaid to better serve the overall needs of these participants.

- There is strong bipartisan support for WIC but the program has never been funded adequately. The rise in birth rates among this nation's poor has increased the numbers of those in need of food and health care services.

- WIC is a successful and cost-effective intervention program that must be safeguarded. Efforts to expand participation in WIC should be encouraged.

THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN,INFANTS, AND CHILDREN (WIC)

WIC, a federal nutrition program which provides supplemental foods, nutrition education, and access to health care services, was implemented in 1972 to respond to the large numbers of pregnant and breastfeeding women, infants, and children who were at "nutritional risk," who lacked adequate food to meet their nutritional needs during critical growth periods. The original language of the statute makes it clear that the intent of the Congress was to reach low-income persons at risk and in need of food, health care, or both, to prevent poor health.

WIC began in 1972 as a 2-year pilot project which had been authorized under Public Law 92-433 as an amendment to the Child Nutrition Act of 1966. Since then, it has grown considerably with only modest changes in program design.

Although enacted in 1972, it was not until October of 1975 that the late Senator Hubert H. Humphrey, as one of his last congressional initiatives, championed legislation to establish WIC as a permanent national program and extend its authorization through 1978 (Public Law 94-105). This piece of legislation was in keeping with congressional intent in 1972 and had a straightforward mission: to save the children of poverty from medical neglect, provide them with adequate diets, and give their mothers decent prenatal care. WIC carries out that mission by serving as an adjunct or referral to medical care and by encouraging a healthy diet as part of the comprehensive package of human welfare assistance. Humphrey stated that,

> *"Looking back over all my years of government service, I am most proud of this program as any in which I have been involved. It represents what is best about America--a dedication to our children and our future and an attempt to nip the poverty cycle in the bud."*

WIC SERVICES

WIC is a three-part intervention program involving supplemental food, nutrition counseling, and close ties to medical care. Each component is believed to contribute to improved pregnancy outcome. Research has not isolated the differential effects of the three WIC components. Generally, the three components are:

Food

Monthly food packages are provided free to participants, based on USDA recommendations and often tailored to the nutritional needs of the recipients. The package often includes such items as infant formula, milk, cheese, eggs, juice, cereal, beans, or peanut butter. The goal is to supplement the diet with foods low-income families may be lacking, such as protein, iron, calcium, and vitamins A and C. WIC foods are provided in one of three ways: vouchers in which clients receive checks or coupons for specific foods which they then purchase in retail stores, home delivery systems in which the foods are delivered to the participant's home, and direct distribution systems in which participants pick up food from a distribution outlet.

Nutrition Education

WIC participants also receive nutrition education in an effort to assist them in improving their dietary practices. Participants must be offered at least two nutrition education sessions per certification period but are not required to attend these sessions to receive the foods.

Improved Access to Health Services

In order to fulfill the function of integrating health care and nutrition, WIC serves to connect women and their families to health services, particularly obstetrical, gynecological, and pediatric care.

ELIGIBILITY

WIC is *not* an entitlement program. It differs from the Food Stamp Program--an entitlement program--which must provide benefits to all those who are eligible for them. WIC caseloads are limited by the extent to which funds are available to serve those in need. The pitfall of WIC not being an entitlement program is illustrated by the following data.

The General Accounting Office has estimated that more than 10.5 million people were income eligible to participate in WIC in 1984. But only about one third of the estimated eligible population were actually served that year.

Due to this limitation--that WIC benefits cannot go to everyone who needs them--federal policy specifies a nutritional priority system to target benefits to those most vulnerable and most in need when funding is not sufficient to serve all eligible applicants. The same General Accounting Office report suggested that the benefits should be targeted to pregnant women (especially adolescents), infants (especially those born prematurely), breastfeeding and postpartum adolescents, and children up to age 2 before children ages 3 to 5.

The Select Committee on Children, Youth, and Families in the House of Representatives has expressed concern that if funding levels do not rise, the next few years will see the numbers of eligible but unserved children increase. The Committee cautions that the costs of essentially eliminating all but the most medically at-risk children from WIC needs to be weighed carefully.

Generally, the target population for WIC includes

- pregnant women,
- postpartum women (up to 6 months after delivery if not breastfeeding),
- breastfeeding women (up to 12 months after delivery),
- infants up to 1 year of age, and
- children up to 5 years of age.

Women and children who fall into one or more of these categories must be of low-income status and be determined to be nutritionally at risk.

Nutritional risk, as determined by The Child Nutrition Act of 1966, includes health problems, such as an iron deficiency, abnormal weight gain during pregnancy, a history of high-risk pregnancies, a previous low birthweight baby, stunted growth, an overweight or underweight problem, and an inadequate dietary pattern.

Federal regulations allow two alternatives to establishing income eligibility for WIC: (1) the state agency can adopt the National School Lunch Program income guidelines, currently 185 percent of the federal poverty guidelines, or (2) the state can adopt a lower standard that corresponds to the state or local income standard for free or reduced-price health care, as long as the standard is not less than 100 percent of poverty. It is important to note that the number of young children living in poverty increased 41 percent between 1979 and 1985. More than 20 percent, 13 million U.S. children, now live below the poverty line. Of black children, 51 percent live in poverty. (The 1988 federal poverty level for a family of three is an annual income of $9,690.)

WIC ADMINISTRATION AND FUNDING

At the federal level, the program is administered by the Food and Nutrition Service of USDA. USDA awards "grants-in-aid" to states to operate their individual programs. Responsibility rests with each state to administer WIC to the participants it determines to be eligible on the basis of general federal guidelines. In addition to the food distribution services, grants are often awarded to health care providers, such as public health, public welfare, or non-profit agencies, to contract with the local WIC program to provide the needed health services to eligible participants.

There are 88 state agencies, which include each of the 50 state health departments, the District of Columbia, Puerto Rico, the Virgin Islands, and Guam. In addition, 34 American Indian associations operate WIC agencies.

WIC is funded annually by appropriations from the Congress. The monies are divided and distributed to the states. Additional allocations may be made later in the year as unused food and money are redistributed. Eighty percent or more of the WIC funds must be spent on food benefits, and up to 20 percent are for administering the program and providing nutrition education benefits. States can grant a portion of their federal funds to local agencies under their jurisdiction to cover their administrative expenses. At both the state and local levels, administrative funds are used for all program costs other than the costs of the food packages.

Funding and participation levels for WIC have grown from $10.4 million and an average of 88,000 WIC participants a month nationally in 1974 to

$948 million and an average of 2,189,000 participants a month in 1982. The funding for fiscal year 1988 is $1.8 billion and should serve about 3.4 million participants.

PROVEN BENEFITS OF FOOD SUPPLEMENTATION PROGRAMS

Internationally, the value of a good nutritional start for both a pregnant mother and her newborn child has been known and acted upon by numerous countries since World War II. Many of these countries have national policies stating that the economic development of their society depends on the health and productivity of their people. Nutritional status and diet are, without question, factors that can positively influence productivity.

Japan, with the lowest infant mortality rate among all the industrialized nations, is just one example of a country that has, in the form of national policy, decided to invest in the growth of its future generation by providing nutritional supplementation, not for altruistic reasons but rather because both the present and future economy depends on a healthy population.

In this country, the benefits of food supplementation and WIC specifically have been under scrutiny for many years. Several groups have attempted to evaluate the effectiveness of the overall program as well as individual aspects. Many studies suffer from difficulties in sampling, timing, and measurement that left the results inconclusive. Much of the controversy was settled when the National WIC Evaluation Study, commissioned by the USDA, released its findings in 1986.

The National WIC Evaluation Study, conducted by David Rush, confirms many of the findings from earlier reports and concludes that WIC has a positive effect on:

- increasing the duration of gestation and birthweight;
- reducing the incidence of late fetal deaths and the neonatal mortality rates;
- earlier enrollment in prenatal care and an improved likelihood that these women will receive adequate prenatal care;
- improving the diets of women and children who had higher intakes of important nutrients, such as protein, iron, calcium, and vitamin C;
- increasing head circumference of infants whose mothers received WIC during pregnancy;
- ensuring immunizations (these children are more likely to have a regular source of health care); and
- improving all of these areas for populations at highest risk of poor birth outcomes, such as teenagers, single mothers, and black and Hispanic women.

Cost-benefit and cost-effectiveness studies have also been done concerning WIC. The figure most often cited is that for every $1 invested in WIC, over $3 is saved in short-term hospital costs. WIC participation in Missouri is associated with a reduction in Medicaid newborn costs of about $100 per infant.

STRATEGIES FOR INCREASING THE NUMBERS SERVED BY THE WIC PROGRAM

Several problems hamper a state's ability to deliver the food, link women and children to health care services, and provide nutrition education services to the eligible population in need:

- Inadequate funding.
- Uncertainty both in the amount and the timing of the final federal grant allocations to states and locales.
- Changes in food costs from year to year; state administrative budgets are tied to food cost allocations.
- Difficulty in predicting participation rates due to shifts in demographic and economic indicators as well as "no show" rates; swings in caseload may affect program quality.
- Lack of participant referral and program coordination; the lack of formalized arrangements between programs makes it likely that participants will not be aware of or receive the full complement of needed services.

State Actions to Increase Their Ability to Reach and Serve Those in Need.

Supplementing federal funds with state funds: Texas is one example of a state that has chosen to expand its WIC program into counties that were either going unserved or where less than 15 percent of the eligible population was being served. Seven million dollars in state funds were appropriated over a 2-year period to reach the additional estimated 817,177 eligible women, infants, and children in need of food.

Incentives to health care providers to care for WIC recipients: New York has a $7.5 million program to reimburse health care practitioners throughout the state for up to 11 visits for medically indigent (WIC recipient) pregnant women not eligible for Medicaid. The program provides free prenatal care to pregnant women whose income is less than 185 percent of the federal poverty level and who are at "high risk" for a poor pregnancy outcome.

Automatic referral of Medicaid patients to WIC and vice versa: Tennessee's Department of Health and the Environment is the state administering agency for both the WIC and Medicaid programs. WIC is integrated with health services for mothers and children provided in the 95 county health departments. The local Medicaid office shares a list of pregnant women who are receiving Medicaid services to be used as a potential referral list for WIC. Health department staff are now screening pregnant women to determine their eligibility for either or both the WIC and Medicaid programs. Other states, including Alabama, Arkansas, Florida, and Maryland, are automatically cross-referring clients.

CONCLUSION

Many pregnant women and their children lack adequate food and nutrition during pregnancy. Since 1972, WIC has provided supplemental foods, nutritional education, and access to health care services to large numbers of pregnant women and new mothers who lack adequate food to meet their nutritional needs. WIC is widely regarded as one of the nation's most successful *and* cost-effective nutrition intervention programs. Any effort to reduce infant mortality and low birthweight will need to include a strong nutritional component, such as WIC.

REFERENCES

Food Research and Action Center, *Poor Infants, Poor Chances: A Longitudinal Study of Progress Toward Reducing Low Birthweight and Infant Mortality in the United States and its Largest Cities, 1979-1984*, Washington, D.C., 1987.

Institute of Medicine, *Preventing Low Birthweight*, National Academy Press, Washington, D.C., 1985.

National Academy of Sciences, Food and Nutrition Board, Committee on Maternal Nutrition, *Maternal Nutrition and the Course of Pregnancy: Summary Report*, Washington, D.C., 1970.

Rush, David, *Evaluation of the Special Supplemental Food Program for Women, Infants, and Children (WIC), Volume 1: Summary*, Research Triangle Institute, 1986

U.S. Department of Health and Human Services, *Better Health for Our Children: A National Strategy*, the report of the Select Panel for the Promotion of Child Health, DHHS Pub. No. (PHS) 79-55071, U.S. Government Printing Office, Washington, D.C., 1981.

U.S. Department of Health and Human Services, Assistant Secretary for Planning and Evaluation, *Improving MCH/WIC Coordination: A Final Report and Guide to Good Practices*, Washington, D.C., August 1986.

U.S. General Accounting Office, *Need to Foster Optimal Use of Resources of the Special Supplemental Food Program for Women, Infants, and Children (WIC)*, GAO/RCED-85-105, Washington, D.C., September 27, 1985.

MATERNAL AND CHILD HEALTH PROVIDER ISSUES

MATERNAL AND CHILD HEALTH PROVIDER ISSUES

A Summary

- Although assuring an adequate supply and distribution of health professionals has long been a goal of the health care delivery system, many continue to have difficulty obtaining care when they need it, particularly low-income and rural and inner city residents.

- Recent developments are exacerbating the problems of access to care for pregnant women and young children. The recent expansions of Medicaid eligibility for pregnant women and children should result in increased numbers seeking care, yet limited provider participation may prevent these individuals from getting the care they need. And rising malpractice insurance costs are causing physicians to limit or drop their obstetrical practices.

- Only 64 percent of obstetrician/gynecologist respondents in a 1987 survey reported participating in Medicaid. Among pediatricians, 82 percent reported participating in 1983.

- Reasons given for providers not participating in Medicaid include low and unpredictable reimbursement, administrative complexities, and rising medical malpractice costs.

- About 12 percent of ob/gyns in 1987 and nearly 19 percent of family physicians reported having dropped their obstetrical practices due to the cost of malpractice insurance.

- Low-income pregnant women are particularly affected by the malpractice situation. Physicians are more likely to stop serving these patients because they are more likely to have problem pregnancies and unhealthy babies. Finding transportation to another provider may be difficult for these women.

- Public clinics and Community and Migrant Health Centers that provide for this population are also facing skyrocketing malpractice and liability insurance costs. Paying these high costs with their already limited funds means fewer funds available for serving patients.

- Federal programs, such as the National Health Service Corps, Community and Migrant Health Centers, and the Maternal and Child Health Block Grant, that increase the availability of health professionals in underserved areas have seen their funding levels either reduced or falling far short of the need over recent years.

- Solutions to the problem of access will have to address Medicaid provider participation issues, medical malpractice concerns, and the expansion of programs targeted to increasing health professionals and resources to underserved areas.

MATERNAL AND CHILD HEALTH PROVIDER ISSUES

Assuring an adequate supply and distribution of primary health care professionals has been a longstanding goal of the health care delivery system in the United States. Public policymakers, communities in need of such providers, health professionals and training programs for health care providers have been involved in finding ways to achieve this goal.

Recent developments have exacerbated the problem of access to care for pregnant women, in particular, and for young children. Perhaps most significant is the rising cost of medical malpractice insurance for obstetrical providers-- obstetricians/gynecologists, family practitioners, and certified nurse midwives-- and its effect on their decisions to limit or drop their obstetrical practices and participation in public health financing and service delivery programs.

The recent expansion of Medicaid eligibility for low-income pregnant women and young children in many states will result in increased numbers seeking care. These expansions are causing states to grapple anew with their chronic difficulties with limited provider participation, especially obstetrical providers, in their programs.

Numerous efforts over the years have encouraged individuals to specialize in primary care, such as family practice, internal medicine, obstetrics, pediatrics, and nursing specialties such as nurse practitioners and certified nurse midwives. While the overall supply of professionals has improved, problems remain. Primary care is often a less attractive specialty to pursue than the better paying, more technical and prestigious medical subspecialties. For those who do practice primary care, rural and inner city areas are commonly seen as less than desirable places to live or work, resulting in significantly higher concentrations of physicians in urban/suburban areas than in rural areas. In addition, the independence of nurse specialists is limited due to restrictive state practice acts or resistance by other providers in the health care system, thus reducing their capacity to meet the health care needs of underserved populations. Finally, funding for public programs that place primary care professionals and resources in underserved areas has been decreased or is not keeping pace with the need.

UNDERSERVED POPULATIONS

Underserved populations have difficulty or are unable to obtain access to primary health care when they need it. These groups tend to use fewer services and receive less health care than is recommended by professionally defined standards. Individuals with low incomes or who lack public (such as Medicaid or Medicare) or private health insurance more often have limited access to care than those with greater financial means and health insurance coverage.[1]

The underserved are also identified by where they live. Rural areas often have fewer physicians, other health professionals, and hospital facilities per capita than suburban and urban areas.

- According to data from the American Medical Association, as of December 31, 1986, the physician-to-population ratio for metropolitan areas was 207.8 to 100,000. In non-metropolitan areas the ratio was 101.9 to 100,000.

The federal government, through the Bureau of Health Care Delivery and Assistance in the Department of Health and Human Services, determines Health Manpower Shortage Areas (HMSAs) for the purpose of identifying populations in need of health care providers, facilities, and resources. As of December 31, 1987, there were 1,944 primary care HMSAs. A number of public programs are targeted to increase access to care by the training and placement of primary providers in HMSAs and by financially supporting health care facilities and services in these areas.

These designations are useful in getting a general "fix" on primary health professional needs in underserved areas. However, because of the time involved with collecting and analyzing the data for determining HMSAs, needs cannot be met in areas that have recently developed shortages, such as those caused by maternity care providers dropping their obstetrical services due to escalating malpractice insurance costs. In addition, specific types of primary health care needs, such as maternity services, are not identified.

THE FEDERAL ROLE

The maldistribution of health care providers, in terms of specialty and geographic needs, has been recognized as a national problem for a number of years. In the early 1960s, the federal government, through the Public Health Service, began to support education and training for health professionals in response to a national shortage of health care providers.[2] By the mid-1970s, studies indicated that the aggregate supply of professionals would be sufficient to meet the health needs of the nation, and the focus of the federal programs began to change to target resources to increase the number of providers in certain specialties, particularly primary care, and to address needs in certain locations, specifically rural and inner city areas.

Recently, the Excellence in Minority Health Education and Care Act of 1987 (P.L. 100-97) was passed into law. Its purpose is to encourage more minorities to work in the health professions. The law authorizes grants to create centers of excellence for minority education in the health professions.

The federal government not only supports the education and training of health professionals, it also provides assistance to underserved populations and areas through the placement of health care providers and facilities.

- The Maternal and Child Health Services Block Grant program (Title V of the Social Security Act) is targeted solely to the health needs of mothers and children. While a primary mission of Title V programs is to assess and plan for the health care needs of mothers and children in each state, including assuring the accessibility of services, funding limitations prevent many states from fully meeting this objective. In most states, however, Title V programs do provide direct services through establishing clinics and helping to place providers where they are otherwise unavailable, especially in underserved rural and urban areas.[3]

- Community and Migrant Health Centers (Sections 330 and 329 of the Public Health Service Act, respectively) provide primary health care in medically underserved rural and urban areas. Migrant Health Centers specifically serve migrant and seasonal farmworkers and their families. A 1987 survey by the Alan Guttmacher Institute estimated that about 660,000 women (that is, 20 percent of all women giving birth) in 1985 obtained prenatal care in maternal and child health clinics or Community and Migrant Health Centers.[4]

National Health Service Corps

The NHSC, implemented in 1972, was the first attempt by the federal government to alleviate the problems of access to health personnel and resources. It is targeted to increase health professional resources (mainly physicians but also dentists, nurses, and others) to areas, populations, and facilities that cannot otherwise recruit and/or retain health care providers. These include rural and urban areas, Community and Migrant Health Centers, the Indian Health Service, and federal prisons. NHSC physicians must be in primary care specialties--family practice, obstetrics, pediatrics, internal medicine, and psychiatry.

- Approximately 2,400 physicians are currently in the field for the NHSC. About 100 nurses and dentists are also in the field.

- NHSC physicians represent between 50 percent and 60 percent of the physician strength of Community and Migrant Health Centers.

- Rural areas receive about 65 percent of the current NHSC placements.

The NHSC assists communities that have been designated as HMSAs to obtain health professionals mainly by placing individuals serving out 2 to 4 year obligations owed to the federal government in return for stipend and scholarship support received during their professional training. Additional programs within the NHSC allow those who are fulfilling their obligations to become directly employed by the federal government with the NHSC providing their salary and related practice costs. Some can also become private practitioners in HMSAs while serving out their obligation.

Physicians represent the vast majority of the NHSC. Originally conceived to primarily address the physician maldistribution problem, it encourages nurse practitioners and certified nurse midwives to practice in underserved areas to a much lesser degree.

Changes in the NHSC. In response to studies in the mid-1970s indicating a surplus of physicians in the country, the funding level for the NHSC scholarship program has been reduced over recent years, with the justification that the national oversupply of physicians would cause a diffusion of providers to underserved areas and, therefore, eliminate the need for NHSC. With fewer scholarship recipients, the field strength of the corps is expected to diminish to approximately 100 in 1994. In that year, only 2 scholars are expected to be available for placement.

The likelihood that the primary care shortage problem will be solved by such diffusion, however, is not at all clear.

- Health manpower shortage areas currently number slightly over 1,900. Although most presently have NHSC providers, a recent survey by the Health Resources and Services Administration showed that only about 35 percent to 40 percent of NHSC providers intend to stay at the assigned locations after their NHSC obligations are met.

- Access for pregnant women needing obstetrical care seems to be worsening in rural areas. Reports of physicians dropping their obstetrical practices due to concerns about liability insurance costs indicate that rural residents are more severely affected.

- Expanded Medicaid eligibility for low income pregnant women and young children, which will result in increased numbers of individuals seeking care, has caused many state Medicaid programs to try and eliminate the gap between the shortage of participating providers in the program and the supply of such caregivers and their willingness to serve this population.

While the NHSC was not conceived to solve all of the nation's problems concerning the need for increased access to health care in underserved areas, it would seem that this is not the time for weakening the NHSC. A number of advocacy and health professional organizations support increased funding for the program. The Congress has been reducing the funding level, but at a pace much slower than the Administration's budget requests each year. For example, for fiscal year 1988, the Congress appropriated $53 million for the NHSC, about $10 million above the Administration's request.

Loan repayment program. A new initiative that has received broad support for its potential to improve the ability of the NHSC program to recruit health professionals and to encourage them to continue practicing in underserved areas is a loan repayment program targeted to individuals who have recently or will soon complete their training (P.L. 100-177). In exchange for joining the NHSC, the government will repay up to $20,000 per year in outstanding educational loans. The funding level of $2.9 million for fiscal year 1988, is expected to allow for 38 health providers to enter the program during the year.[5] Many consider this a small number given the need for providers and the shrinking size of the scholarship program. Appropriations legislation pending in the Senate would increase the funding level for fiscal year 1989 to $8.0 million and earmark a portion of the increase for assistance to obstetrical providers (Senate Appropriations Committee Report 100-399).

It is anticipated that signing agreements with the program more closely to the point of service will help reduce the possibility of default, a persistent problem with the scholarship program which most participants join at the beginning of their professional training. In addition, the loan repayment program can potentially allow the NHSC program to choose participants who can best meet public health needs, such as maternity and perinatal care, at the current time.

THE STATE ROLE

States have programs to assist health professional students, especially medical students, with educational expenses in return for working in rural or other underserved areas for a specified period of time. A common state initiative involves a type of tuition reimbursement or loan repayment program, not unlike the new loan repayment program in the NHSC, in which the state directly offers loans or pays back loans obtained at a private lending institution for medical and other health professionals in exchange for service in underserved areas for a specified amount of time. Such programs may be fully funded by the state or may be supplemented by communities in need of such health care resources.

In response to provider participation problems in their public programs, such as Medicaid, some states are more aggressively recruiting alternative providers, such as certified nurse midwives and nurse practitioners, for their maternity care programs either as employees of state and local health units or through Medicaid reimbursement policies. The potential for this as a solution, however, may be limited because of the availability and scope of practice for such providers. There are only about 2,500 practicing certified nurse midwives in the United States. Also, the medical and hospital establishments in some areas are resistant to their involvement in practicing obstetrics and this can also be a barrier to the ability of nurse midwives' to fill unmet maternity care needs.

Additional examples of efforts to meet the need for health resources include special programs in university and other educational institutions that educate health professionals. Residency and graduate training programs can include rotations to rural areas, satellite clinics, or public clinics. These experiences are geared to encouraging students to work in primary care and underserved areas after graduation. The state Title V agencies (Maternal and Child Health Programs) often assist in identifying populations and areas in need of services and in supporting the education of health professionals to serve such groups.

ISSUES AFFECTING ACCESS TO MATERNAL AND CHILD HEALTH SERVICES

Physician Participation in Medicaid

Physician participation in Medicaid has long been recognized as critically important to making the program successful in increasing access to quality medical care for low income individuals. Medicaid is the major source of financing of health care for low-income pregnant women and infants.

- In 1985, 17 percent of all births were covered by Medicaid. Federal and state Medicaid payments totaled $1.8 billion for maternity care.

- Children under age 21 represented 50 percent of all Medicaid recipients in 1986. Medicaid payments for children under age 21 in 1985 were $8.0 billion.

The limited ability of state Medicaid programs to attract physicians to their programs has been a difficult problem to solve. Physicians, whose participation rates are usually identified through self reporting, may indicate that they participate in the program, yet they may only have a few Medicaid patients on their caseloads. A 1987 study by the Office of Technology Assessment reports that participation among obstetrician/gynecologists lags behind other specialties, while pediatrician participation is about average. The OTA study further pointed out that rural areas have higher obstetricians/gynecologist participation than do urban areas.

- A 1987 survey of members by the American College of Obstetricians and Gynecologists (ACOG) showed that only 64 percent of respondents reported participating in Medicaid.

- A survey of pediatricians published in 1986 reported that 82 percent of pediatricians participated in Medicaid in 1983.

Limited Medicaid reimbursement. An important factor in whether a physician will participate in Medicaid is the level of reimbursement for services. Not only are Medicaid payments less than private third party payment levels in nearly every instance, substantial variation exists between state programs as well.

- While in 1987 the average Medicaid global payment rate for maternity care (includes prenatal, vaginal delivery, and postpartum care) was $596, the states differed greatly, ranging from $236 in New Jersey to $1,471 in Massachusetts.

- An ACOG survey found the median physician charge for total maternity care to be $1,000 in 1986, with the averages ranging from $840 in the rural Midwest to $3,422 in a large city in the East.

Administrative complexities. The amount of documentation required of providers by federal and state regulations can be burdensome while reimbursement may be delayed and unpredictable. Also, because many states do not guarantee continuous eligibility through the entire pregnancy and postpartum (post-delivery) period, if a women happens to lose her Medicaid eligibility due to an increase in her income, the provider risks not being paid for services rendered.

Such issues as discussed above have helped to create chronic problems for states, providers, and Medicaid eligible pregnant women and infants in need of care. In recent years, some states have responded to these problems by increasing Medicaid payments for maternity care and by working with obstetrical providers to identify other issues needing attention and resolution. Also, some states' Medicaid and Title V agencies are collaborating to better serve pregnant women and children through their respective programs. While the effect of these efforts is still uncertain, they may prove beneficial to making Medicaid and other public programs more workable for states, providers, and their patients in need of care.

Rising Medical Malpractice Insurance Costs

One of the most significant issues concerning access to care for pregnant women, especially low-income women and those on Medicaid, is the rising cost of malpractice and liability insurance for all maternity care providers, especially obstetrecians/gynecologists. Numerous reports and surveys indicate that, in response to these increasing costs, providers are limiting or dropping their obstetrical practices. Professional malpractice and liability insurance costs can constitute a large portion or actually exceed the Medicaid reimbursement rate for obstetric services, creating another disincentive for treating Medicaid patients or other low-income individuals who may be unable to fully pay for their care.

- About 12 percent of obstetricians/gynecologists responding to a 1987 survey by ACOG reported having dropped their obstetrical practices due to the cost of malpractice insurance.
- The same survey showed that the average annual liability insurance premium for obstetricians/gynecologists went from about $11,000 in 1982 to over $37,000 in 1987, more than a threefold increase in just 5 years.
- A 1987 survey by the American Academy of Family Physicians found that nearly 19 percent of responding physicians had stopped delivering babies citing the cost of malpractice insurance and the threat of a lawsuit as the primary reasons.

Other providers affected by rising malpractice costs. Not only have physicians been affected by these rising costs, certified nurse midwives, who faced a nationwide cancellation of their coverage a few years ago, are now experiencing significant increases in their annual premiums also, which rose from an average of $800 prior to 1985 to $3,500 in 1986. Community and Migrant Health Centers and physicians who work for them are another group of primary care providers offering maternity and well-child care to thousands of low-income and Medicaid patients that have been affected by skyrocketing malpractice and general liability insurance costs. In 1985, the Centers were paying an average of $800 to $900 in annual malpractice premiums for each of their physicians. One year later, they paid $12,000 per provider. This significant jump was mostly due to increases in their obstetrical insurance rates.

Malpractice risks. Some obstetrical providers believe that caring for Medicaid patients results in a greater likelihood of being sued. Because Medicaid patients, as a group, are more likely to have poor birth outcomes, obstetricians fear they are more likely to sue also. This perception, however, has not been substantiated by empirical evidence.

Effects of rising malpractice costs on access to care. High malpractice insurance costs are causing providers to drop their obstetrical services altogether or to limit their care to low-risk cases only. While data are limited on the effect this is having on access to care, state level studies and reports in the popular press indicate that this is causing a serious problem for some individuals, especially rural residents, who already are more likely to have limited access to care. If the one family physician in town is no longer delivering babies, they have to find another provider elsewhere. This is especially difficult for low-income individuals.

The malpractice problem has been largely viewed as an insurance and cost issue with solutions being attempted through state tort reforms and tightening of licensure and disciplinary procedures. However, survey data from provider organizations and others clearly indicate that physicians are lowering their participation in public programs due to increases in malpractice insurance costs. More comprehensive and national level data are needed to assess the effects of malpractice costs on access to maternity and other health services.[6]

IMPLICATIONS FOR POLICY DEVELOPMENT

The full range of issues concerning maternal and child health providers has important effects on access to care for pregnant women and their infants, particularly those with low incomes and those living in medically underserved areas. Because these problems concern federal and state programs and policies as well as caregivers themselves, solutions must come from many fronts.

Longstanding problems with provider participation in public programs need to be addressed. With the expansions of Medicaid eligibility for pregnant women and young children, some states have taken the lead in examining their programs to determine how this population can be better served. Their experience should be instructive for other states and the federal government in changing Medicaid policy. The National Governors' Association has recently conducted a study of provider participation problems among state Medicaid and Title V Maternal and Child Health programs ("Provider Participation in Public Programs for Pregnant Women and Children"). The Institute of Medicine also has relevant studies underway. Such current information should be useful to finding ways to improve the present situation.

Increasing reimbursement rates or changing fee structures may help encourage provider participation in public programs, but concerns about liability risks when caring for low-income patients will remain unless additional efforts to understand and address these issues are made. Providers' concerns may be reduced through collaboration between public programs, such as state Medicaid and Title V agencies, to better coordinate and assure comprehensive, risk-appropriate care from the moment a woman finds she is pregnant through the delivery and postpartum periods. Additionally, some states have begun addressing malpractice issues directly by subsidizing insurance costs for providers serving clients in underserved areas or in public clinics. Others are limiting physician liability for services provided to clients in public programs.[7]

Although malpractice insurance is traditionally a state level concern, the rising cost of insurance is having a negative effect on access to care across the country and the malpractice problem is being recognized as a national issue. Addressing the malpractice problem must be an integral part of any Congressional deliberations, as well as those in state legislatures, about improving access to care for underserved and uninsured Americans.

The National Governors' Association survey mentioned above found that a large number of state Medicaid and Title V agencies have not been actively involved in their states' and other debates about resolving malpractice issues, yet virtually all states in recent years have considered or passed legislation to deal with malpractice concerns. These agencies plus health care providers and advocates must be involved in broadening the focus on malpractice and drawing policymakers' attention to its effect on access and solutions for eliminating these problems.

States have another source of funds with which to improve access to care for pregnant women and young children. Costs being incurred by state Title V programs for direct services to pregnant women and children will be saved as state Medicaid programs are expanded for pregnant women and young children. States could benefit from using these savings to fulfill some of the many other maternal and child health needs of their residents.

The federal government's response to problems of access created by the malpractice problem has been limited. Funds have been transferred from the NHSC to the Community and Migrant Health Centers programs to help pay the salaries and malpractice insurance premiums of NHSC providers employed by the Centers. Also many Centers are also starting to help pay for all or some of their physicians' malpractice insurance "tail coverage"[8] when they leave the Centers' employment. Health Centers program staff in the Department of Health and Human Services indicate that these innovative efforts are being well received by potential physician employees.[9]

Another federal effort during the past 4 years has been to place as federal employees all the obstetricians/gynecologists obligated to serve in the NHSC. The direct federal hiring of these providers obviates the need for them to purchase malpractice insurance because they are covered by the federal tort system (Federal Tort Claims Act). Claimants then pursue any legal action through that route rather than the state tort system. Eliminating this expense frees up funds for other purposes, such as salaries for providers or direct patient care services.

CONCLUSION

Access to maternity and pediatric care is affected in a number of ways: financial resources and health insurance coverage, knowledge that one needs health care, and the availability of providers and their willingness to take one's case, among others. The problems of access to care and the maldistribution of maternal and child health providers is a longstanding problem, one that has been recognized by all levels of government, health professionals, and the schools that educate them. Still, problems remain and seem to be growing worse for certain populations. Federal support for addressing such problems, through programs like the Community and Migrant Health Centers and the NHSC, is stagnant or rapidly diminishing. Such shortfalls prevent these programs from keeping pace with the need in underserved areas or from responding to new issues affecting access, such as the malpractice problem.

Malpractice insurance costs are causing an exodus of obstetrical providers, leaving pregnant women behind in search of prenatal care. This recent development adds to access problems for populations already most affected by the maldistribution of primary care providers.

The need for additional maternity and pediatric caregivers to provide services to new Medicaid eligible pregnant women and young children is another issue confronting virtually all the states. Improving provider participation in Medicaid, always a difficult problem, is now more acutely needed than ever before.

Comprehensive and national level data and information are needed to understand the magnitude of the problem of provider availability and to identify potential solutions. Public health officials, health care providers and others in key positions can educate federal and state policymakers about their roles in caring for the health of mothers and children. Only through concerted efforts will access be improved and barriers torn down for those in need of care.

NOTES

1. A detailed discussion of maternal and child health care financing issues can be found in the Issue Brief, "The Financing of Maternity and Infant Care," in this volume.

2. The Health Professions Educational Assistance Act of 1963 (P.L. 88-129) became Title VII of the Public Health Service Act; the Nurse Training Act of 1964 (P.L. 88-581) added a new Title VIII to the act.

3. For further discussion of the Title V program, see the Issue Brief, "Title V Maternal and Child Health Block Grant," in this volume.

4. For further discussion of the role of Community and Migrant Health Centers in providing maternity and infant health care, see the Issue Brief, "Community and Migrant Health Centers," in this volume.

5. States are receiving $1 million of this amount to develop loan repayment programs to be modeled after the federal program.

6. For further discussion, see "Malpractice and Liability: An Obstetrical Crisis," published by the National Commission to Prevent Infant Mortality. Also, ACOG and the American Academy of Family Physicians, as well as state-level organizations, have conducted surveys of their members to assess the magnitude of malpractice insurance costs and the effects of such costs on physician practices. The U.S. Public Health Service ("Medical Malpractice Liability Coverage in the 1980s: Threat to Patient Access to Health Care?," August 31, 1986) studied the relationship between access and the current malpractice situation through reports of national organizations and reviews of surveys and popular press accounts of access problems.

7. In Virginia, legislation was adopted in 1987, "The Virginia Birth-Related Neurological Injury Compensation Act." Faced with both escalating premiums and a statewide insurance cancellation for obstetricians/gynecologists in 1986, the state legislature adopted this proposal that was agreed to by physicians and insurers to compensate, on a no-fault basis, the economic losses of the most extreme cases of birth-related injury: infants with brain or spinal cord injuries who will suffer lifelong impairments. The compensation mechanism is a fund financed by a range of fees paid by all physicians and hospitals in the state.

Missouri passed legislation in 1987 to help physicians who provide obstetrical or pediatric services in a city or county health clinic to low-income or Medicaid patients. Any damage award against the physician will be paid out of the Missouri State Legal Expense Fund; the physician's private liability insurance will not be considered a source of funds in the settlement of these cases. Limits on such liability are determined under the medical malpractice statutes that were enacted in 1986 in Missouri.

8. Most malpractice insurance policies are claims-made policies, meaning that they cover incidents that happen while the physician or other provider is insured by the same company. In conjunction with a claims-made policy, a tail policy must be purchased for coverage against suits that may be brought after the claims-made policy has expired, such as upon retirement or changing insurance companies.

9. The Congress is considering legislation (H.R. 4783) that would provide funds to Community Health Centers to help cover the costs of malpractice insurance for obstetrical providers in the Centers.

REFERENCES

The Alan Guttmacher Institute, *Blessed Events and the Bottom Line: Financing Maternity Care in the United States*, New York, 1987.

American Academy of Family Physicians, "A Professional Liability Study," Kansas City, Missouri, 1987.

American College of Obstetricians and Gynecologists, Committee on Health Care for Underserved Women, "Ob/Gyn Services for Indigent Women: Issues Raised by an ACOG Survey," Washington, D.C., May 1988.

American College of Obstetricians and Gynecologists, "Professional Liability and its Effects: Report of a 1987 Survey of ACOG's Membership," Washington, D.C., March 1988.

Cislowski, Joseph A., *Health Care for Children: Federal Programs and Policies*, U.S. Congress, Congressional Research Service, 88-217 EPW, Washington, D.C., June 16, 1988.

Institute of Medicine, *Preventing Low Birthweight*, National Academy Press, Washington, D.C., 1985.

Klebe, Edward, Health Professions Education and Nurse Training Programs: Titles VII and VIII of the Public Health Service Act, U.S. Congress, Congressional Research Service, IB88055, Washington, D.C., April 7, 1988.

National Association of Community Health Centers and National Rural Health Association, *Health Care in Rural America: The Crisis Unfolds. Report to the Joint Task Force of the National Association of Community Health Centers and the National Rural Health Association*, Washington, D.C., May 1988.

National Governors' Association, *Provider Participation in Public Programs for Pregnant Women and Children*, Washington, D.C., 1988, in press.

Perloff, Janet D., Phillip R. Klete, and Kathryn M. Neckerman, "Recent Trends in Pediatrician Participation in Medicaid," *Medical Care*, Vol. 24, No. 8, August 1986.

U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future*, OTA-H-345, Washington, D.C., U.S. Government Printing Office, February 1988.

U.S. Department of Health and Human Services, Public Health Service, Health Resources and Services Administration, "Fiscal Year 1989 Justification of Appropriation Estimates for Committee on Appropriations," Vol. I, Washington, D.C.

U.S. Department of Health and Human Services, *Report of the Secretary's Task Force on Black and Minority Health, Volume II: Crosscutting Issues in Minority Health*, August 1985.

U.S. General Accounting Office, *Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care*, GAO/HRD-87-137, Washington, D.C., September 1987.

U.S. General Accounting Office, *Medical Malpractice: No Agreement on the Problems or Solutions*, GAO/HRD-86-50, February 1986.

U.S. General Accounting Office, *Medical Malpractice: A Framework for Action*, GAO/HRD-87-73, May 1987.

MINORITY POPULATIONS

MINORITY POPULATIONS

A Summary

- In 1985, almost 3.8 million infants were born in the United States; 80 percent were white infants, 16 percent, black; 3 percent, Asian; and 1 percent, American Indian and Native Alaskan (collectively referred to as Indians). *

- In the same year, 40,030 infants died before reaching their first birthday: 70 percent of these deaths were of white infants and 28 percent, black infants.*

- Although the 1985 infant mortality rate was 10.6 infant deaths per 1,000 live births, the rate for blacks (18.2) was virtually twice that for whites (9.3). *

- Significant disparities exist among and within racial and ethnic populations for infant mortality, low birthweight rates, and initiation of prenatal care.

- Overall, 6.8 percent of infants born in 1985 were of low birth weight (less than 2,500 grams or 5.5 pounds). For racial and ethnic groups, this ranged from 5.0 percent for Chinese infants to 12.4 percent for black infants. Within the Hispanic population, it ranged from 5.7 percent for Central and South Americans to 8.7 percent for Puerto Ricans. **

- Among all women, 5.7 percent received late (beginning in the third trimester of pregnancy) or no prenatal care. This ranged from 4.7 percent for whites to 11.5 percent for Indians. For Hispanics, the range was from 3.7 percent for Cubans to 15.5 percent for Puerto Ricans. **

- Poor pregnancy outcomes are more common in mothers who are in their teens, unmarried, less educated, and have unintended pregnancies, all of which are more prevalent in minority groups.

- The Hispanic infant mortality rate and incidence of low birthweight are similar to that for whites, despite their socioeconomic status--a risk factor for poor pregnancy outcomes--being similar to blacks. Possible explanations for this include a low incidence of smoking and substance abuse among Hispanic women, adequate nutrition, strong cultural norms of social support, possible underregistration of Mexican infant deaths, and other unknown factors.

- The infant mortality rate for Indian infants (9.1) is lower than the overall U.S. rate. Deaths of Indian infants may, however, be underreported due to a lack of consistency in recording race on birth and death certificates; these deaths are often recorded as white rather than Indian. Such underreporting may also occur for Asian and Hispanic infant deaths.

- The postneonatal mortality rate (infant deaths occurring from 28 days to one year after birth) for Indians substantially exceeds the U.S. and white rate. Excessive postneonatal deaths among Indian infants most often result from preventable accidents and treatable acute medical conditions.

** Comparable national data are not available for births and deaths of Hispanic origin.*

*** Data on births of Hispanic parentage are based on 23 reporting states and the District of Columbia.*

MINORITY POPULATIONS

Infant mortality--the number of babies born alive but who die before their first birthday--has been viewed historically as a sensitive indicator of the well-being of any society. Significant progress has been made over the past 4 decades to reduce the number of infant deaths in the United States, from 47.0 deaths per 1,000 live births in 1940 to 10.6 in 1985. (See fig. 1.) While all racial and ethnic groups have enjoyed this decline, substantial disparities still exist among and even within subgroups. The black infant mortality rate (18.2) is virtually twice as high as the rate for white infants (9.3).[1]

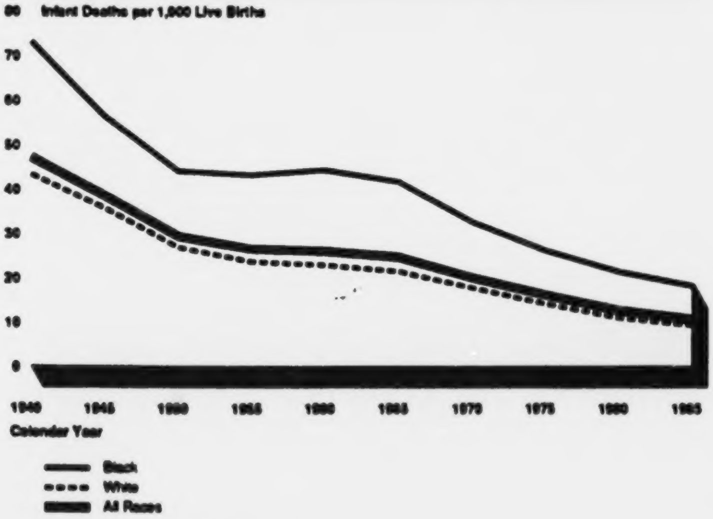
The incidence of low birthweight--infants born weighing less than 2,500 grams or 5.5 pounds--is highly related to infant mortality and morbidity.[2] These infants are almost 40 times more likely to die within the first month of life and account for two-thirds of neonatal deaths. Of all births in 1985, 6.8 percent were of low birthweight.

Low birthweight is another indicator of existing disparities between racial and ethnic groups. The percentage of black infants born with low birthweight is more than twice that for white infants (12.4 percent and 5.6 percent, respectively, in 1985). Significant disparities also exist between and among other racial and ethnic groups for low birthweight, particularly among Hispanic subpopulations, as shown in table 1.

Several risk factors associated with poor birth outcomes (infant deaths and/or low birthweight infants) are often related to low socioeconomic status. These risk factors include

- low income and inadequate insurance coverage that often reduce access to appropriate medical care,
- preexisting health conditions,

Figure 1: Infant Mortality Rates, 1940-85



Source: National Center for Health Statistics

Table 1
Infant Mortality and Low Birthweight Ratios by Race and Ethnicity, 1985

	Infant Mortality[a]	Low Birth-weight[b]
All groups	10.6	6.8
White	9.3	5.6
Black	18.2	12.4
Hispanic[c]	8.6	6.2
Mexican	8.5	5.8
Puerto Rican	8.1	8.7
Cuban	7.6	6.0
Central and South American	d	5.7
Other	8.9[e]	6.8
Asian and Pacific Islander	6.1	6.1
Chinese	5.3	5.0
Japanese	4.4	5.9
Hawaiian	d	6.4
Filipino	5.5	6.9
Other[f]	6.7	6.1
American Indian and Alaska Native	9.1	5.9
Other	4.8	d

[a] *Infant deaths per 1,000 live births.*
[b] *Percent of live births under 2,500 grams.*
[c] *Hispanic data are not comparable to that provided for other groups. Mortality data are based on 17 reporting states and the District of Columbia; low birthweight data are based on 23 reporting states and the District of Columbia.*
[d] *Not specified.*
[e] *Includes Central and South American and Other and Unknown Hispanic.*
[f] *Includes deaths among Hawaiian and part-Hawaiians.*

SOURCE: National Center for Health Statistics.

- poor nutrition,
- inadequate housing and crowded living conditions,
- limited maternal education,
- stressful work environments,
- disrupted families and lack of social supports, and
- problems of transportation and child care which impede use of services.

All of these risk factors are more prevalent among low-income and minority women. Furthermore, poor pregnancy outcomes are more common in teenage mothers, unmarried mothers, and in cases of unintended births, all of which are more common in minority groups.

Even when many of the social and economic risk factors, such as education, marital status, initiation of prenatal care, number of births per mother, and maternal age, are taken into account, significant differences still exist between white and non-white groups in terms of birth outcomes. This suggests that this is a difficult, complex issue with no simple solutions.

INFANT BIRTH AND DEATH STATISTICS, 1985

In 1985, almost 3.8 million infants were born in the United States. The majority of these births (80 percent) were white infants. In the same year, 40,030 infants died before reaching their first birthday, for an overall infant mortality rate of 10.6 per 1,000 live births. In absolute numbers, the majority of these deaths (70 percent) were white infants. But the rate of deaths for black infants (18.2) is virtually twice that for whites (9.3), as shown in table 2.

Comparable national data for infant births and deaths are not available for the Hispanic population (an ethnic rather than a racial designation). Available data, as reported in table 1 and elsewhere in this paper, are based on reporting by less than half of the states. However, data on births of Hispanic parentage, reported by 23 states and the District of Columbia (in which 92 percent of the U.S. Hispanic population reside), indicate that 372,814 infants were born to Hispanic mothers in 1985.

Table 2
Live Births and Infant Deaths, by Race, 1985

	Live Births		Infant Deaths		
	number	*percent*	*number*	*percent*	*rate*
All races	3,760,561	100.0	40,030	100.0	10.6
White [a]	2,991,373	79.5	27,864	69.6	9.3
All other	769,188	20.5	12,166	30.4	15.8
Black	608,19	16.2	11,063	27.6	18.2
Asian [b]	115,616	3.1	701	1.8	6.1
Indian [c]	42,646	1.1	389	1.0	9.1
Other	2,733	.0	13	.0	4.8

[a] *About 95 percent of births to Hispanic women are classified as white.*

[b] *Includes Asian subgroups (Chinese, Japanese, Hawaiian, and Filipino) and Pacific Islanders and Other Asians (Asian Indian, Cambodian, Korean, Laotian, and Vietnamese).*

[c] *The composite group of American Indian and Alaska Natives is referred to as "Indian."*

SOURCE: National Center for Health Statistics.

The Hispanic infant mortality rate, determined on the basis of reporting by 17 states and the District of Columbia, was 8.6 per 1,000 live births, compared to 10.2 for the non-Hispanic population in those same reporting areas. Because of the limited number of states reporting,[3] the National Center for Health Statistics urges caution in generalizing from this data to the Hispanic population of the entire United States.[4]

Neonatal and postneonatal infant mortality

Infant mortality is generally broken into two periods: the neonatal period (from birth to 28 days) and the postneonatal period (from 28 days to one year). At the turn of the century, postneonatal deaths accounted for most infant deaths; presently, neonatal deaths are predominant. Neonatal deaths are thought to reflect preexisting health conditions of the mother and the medical care she and her baby receive during pregnancy, at the time of delivery, and shortly thereafter. Major improvements in the neonatal death rate have occurred in the past 2 decades (see fig. 2).

Postneonatal mortality is more reflective of living and environmental conditions and medical care for treatable or controllable conditions such as infection and accidents. These two classifications of infant mortality--the neonatal and postneonatal periods--are not entirely separate since the factors that influence a woman to obtain early prenatal care may be the same things that influence living conditions and the availability and use of health services after birth.

Black infant mortality rates are virtually twice that for whites during both neonatal and postneonatal periods, as shown in table 3.

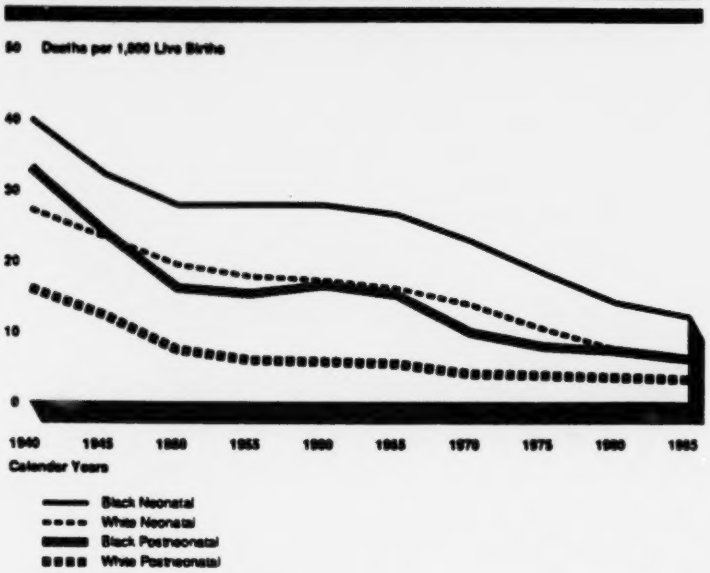
Such aggregate data, however, mask underlying differences between minority groups. Indians, for example, have an overall infant mortality rate of 9.1, below the national average as well as that for whites.[5] The postneonatal rate, however, is 5.0, higher than the national average and closer to the black rate. Reasons for this will be explored further in a more detailed discussion of Indians.

Utilization patterns for prenatal care

Utilization of prenatal care is highly related to pregnancy outcome. It has been clearly demonstrated that adequacy of prenatal care, measured by the timing of the initial visit, number of visits, and hospital service type, is associated with better pregnancy outcomes.

Once again, utilization patterns for prenatal care vary across racial and ethnic populations. Non-Hispanic whites come closest as a group to beginning prenatal care in the first trimester of pregnancy, as recommended by the American College of Obstetricians and Gynecologists.

Figure 2: Neonatal and Postneonatal Mortality Rates, 1940-85



Source: National Center for Health Statistics

Table 3
Infant Mortality, Neonatal Mortality, and Postneonatal Mortality Rates, by Race and Ethnicity, 1985

	No. of deaths per 1,000 live births		
	Total	Neo-natal [a]	Post neo-natal [b]
All groups	10.6	7.0	3.7
White	9.3	6.1	3.2
Black	18.2	12.1	6.1
Hispanic [c]	8.6	5.4	3.2
Asian	6.1	3.6	2.4
Indian	9.1	4.2	5.0

[a] *Neonatal deaths occur within 28 days of birth.*

[b] *Postneonatal deaths occur from 28 to 365 days after birth.*

[c] *Data, which are based on information from 17 states and the District of Columbia, are not comparable to other groups and should not be generalized to the entire Hispanic population of the U.S.*

SOURCE: National Center for Health Statistics.

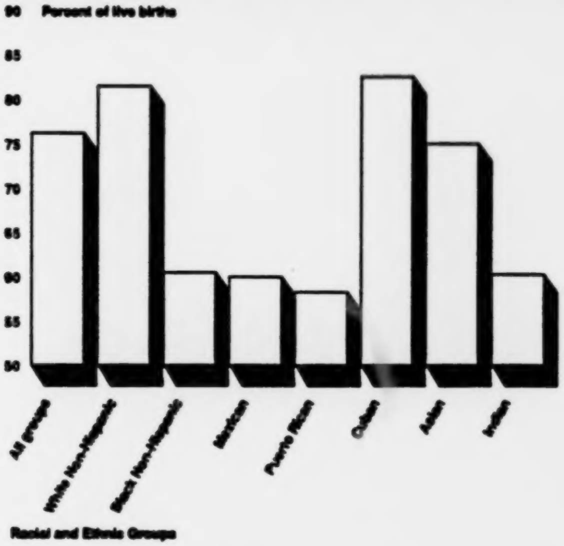
Puerto Ricans are the least likely to begin early prenatal care, as shown in figure 3.

There are also significant variations in the proportions of women who receive late or no prenatal care. Among all women nationwide, 5.7 percent had late (beginning in the third trimester) or no prenatal care, compared to Indians, 11.5 percent; blacks, 10.0 percent; Asians, 6.1 percent; and whites, 4.7 percent. Within the Hispanic population was also great disparity. Among all Hispanic women, 12.4 percent had late or no prenatal care in 1985, ranging from Cubans at 3.7 percent to Puerto Ricans at 15.5 percent.

RISK FACTORS FOR MINORITY GROUPS

Risk factors that contribute to poor pregnancy outcomes for minority populations can be classified in three groups: (1) general health status of the mother, (2) maternal demographic characteristics and socioeconomic status, and (3) community characteristics like the type of services offered and access to those services. [6]

Figure 3: Prenatal Care Began During First Trimester, by Race and Echnicity, 1985



Source: National Center for Health Statistics

Mother's general health status

Direct precursors of poor pregnancy outcomes include the general health status of women and medical illnesses that occur during pregnancy, pregnancy-induced conditions like hypertension, and chronic medical diseases like diabetes which can be exacerbated by the pregnancy. Some of these medical conditions, such as hypertension and diabetes, are more common among certain minority groups.

Preexisting medical conditions like heart disease, renal disease, diabetes, sickle cell anemia, and chronic hypertension increase the risk of low birthweight and neonatal mortality. Racial and ethnic predisposition to certain diseases magnifies the risk for that group. For example, gestational diabetes and less severe chronic diabetes result in large-for-gestational-age infants who are at increased risk for poor pregnancy outcome and congenital anomalies. Indians and Hispanics have a higher incidence of diabetes than most other groups. In addition, blacks have high incidences of sickle cell anemia, chronic hypertension, and heart disease. Asians appear to be at risk to transmit hepatitis B virus.

Substance abuse--cigarette smoking, alcohol ingestion, legal and illegal drug usage, and caffeine consumption--adversely affects the fetus.[7] The lower incidence of smoking among Hispanic women than among non-Hispanic women is thought to be at least in part responsible for favorable birth outcomes, especially for Mexican women. Recent analysis, however, shows that smoking may be increasing among Hispanic women.

While profiles of drinkers in various studies are somewhat contradictory, it appears that whites drink more than blacks during pregnancy, and blacks drink more than Hispanics. High rates of alcoholism among Indians, which leads to higher rates of fetal alcohol syndrome, is of particular concern.

Groups at high nutrition risk include pregnant teens who have their own growth-related nutritional requirements, are at an age when thinness is of such importance, and are not apt to follow nutritious diets. Minority groups, particularly blacks and Hispanics with high proportions of teen births, are more likely to have poor nutrition. Nutritional status, while part of a pregnant woman's general health status, is very much a reflection of her socioeconomic status.

Maternal demographic characteristics and socioeconomic status

A second set of risk factors for poor pregnancy outcomes include maternal demographic characteristics, such as age and level of education, which are generally used as indicators of socioeconomic status. Approximately 60 percent of premature deliveries have been associated with low socioeconomic status. Studies consistently show that malnutrition, psychological and physical stress, and a lack of health insurance--all consequences of low socioeconomic status--have an adverse impact on pregnancy outcome.

Maternal age has its greatest impact on pregnancy outcome for women younger than 18, although it is also important for women older than 34. Teen mothers are at risk from both biological and socioeconomic factors. Biological problems, especially for very young teens, include physiological immaturity for pregnancy and nutritional requirements for the mother's own growth which compete with the needs of the developing infant. Socioeconomic factors include lower levels of education and economic well-being. Teens are more likely to be unmarried, have an unplanned pregnancy, and have limited occupational skills and family resources which often lead to dependence on welfare or their families.

The effect of maternal age on infant health outcome does not end with the birth. Babies of teen mothers, even healthy ones, often exhibit some deficits in cognitive development, lower IQ scores, and social adjustment problems compared to children of older mothers. Infants of teen mothers are also at increased risk of other health problems and postneonatal mortality.

The proportion of teenage mothers varies greatly across racial and ethnic populations. In 1985, 13 percent of all births occurred to mothers aged 19 years or less, compared to blacks, 23 percent; Indians, 19 percent; Hispanics, 17 percent; whites, 11 percent; and Asians, 6 percent.

Parity (the number of live births a woman has had) is associated with pregnancy outcomes. A women having more than five or six births is at higher risk for poor pregnancy outcome. The risks of high parity are exacerbated by short intervals between births, especially for teens delivering their third (or more) child. The relationship of parity and maternal age can also result in adverse outcomes; for example, women over age 35 expecting their first child and women under age 18 expecting their second (or more) child are at greater risk. Parity is generally higher in black, Hispanic, and some Southeast Asian groups.

Maternal education is often used as an indicator of socioeconomic status. A low level of education is generally associated with poor pregnancy outcomes. Conversely, as educational attainment increases, women are more likely to start prenatal care earlier and are less likely to have late or no care, which can result in improved pregnancy outcomes.

Indians and blacks generally have completed fewer years of education than whites. In 1985, 21 percent of all live births occurred to mothers with less than 12 years of education, compared to Indians, 37 percent; blacks, 32 percent; Asians, 19 percent; and whites, 18 percent. Among Hispanics, 44 percent of births occurred to mothers with less than 12 years of education, ranging from 21 percent of Cuban mothers to 59 percent of Mexican mothers.

Out-of-wedlock births, like limited education, is an often-used indicator for low socioeconomic status. Unmarried mothers often experience poor pregnancy outcomes, although the effect may be greater for whites and Hispanics than for blacks. Generally, unmarried mothers have poorer birth outcomes than do married women.

In 1985, 22 percent of all births were to unmarried women, compared to blacks, 60 percent; Indians, 41 percent; whites, 15 percent; and Asians, 10 percent. Among Hispanic women, 30 percent of births were to unmarried women. Puerto Ricans had the highest proportion at 51 percent, followed by Mexicans, 26 percent, and Cubans, 16 percent.

Community characteristics

This risk group includes factors that influence the social, political, cultural, economic, and physical environment of the mother. Studies have demonstrated associations between low birthweight and other poor pregnancy outcomes and community socioeconomic characteristics like urban crowding, low per capita income, low per capita energy consumption and food allowance, lack of radio and television, and few physicians.

Cultural norms often interact with socioeconomic realities. One study found black mothers did not receive care to the same extent as did white mothers. But it was further noted that mothers of low education, regardless of race, did not receive care as much as those with higher levels of education. Limited access to prenatal care for Hispanics in the southwestern United States has been associated with some cultural phenomenon, such as language differences which affect physician availability, limited use of preventive health care, and a tradition of male dominance within families which lessens a woman's ability to make independent choices.

But access to prenatal care seems to be more influenced by low income, education, and lack of health insurance. Health insurance in particular is an important factor in providing financial access to prenatal care. In 1986, health insurance coverage varied considerably among racial and ethnic groups, as shown in table 4.[8]

A recent General Accounting Office study of low-income women found that those most likely to obtain insufficient prenatal care were women who were uninsured, poorly educated, black or Hispanic, teenagers, or from large urban areas. Most likely to obtain adequate care were women who were well educated, white, in their early thirties, had private or public health insurance, and lived in rural communities.

Even after controlling for economic, social, environmental, and medical differences as well as utilization of prenatal care between minority and nonminority groups, various studies have noted that differences still exist in birth outcomes. One recent analysis, based on 1983 data, found that black women were three times as likely as white women to have a baby with a very low birthweight (less than 1,500 grams) and more than twice as likely to have a baby with a moderately low birthweight (1,500 to 2,500 grams). Another study stated that minorities have been found to have infants born one week earlier and at a birthweight 270 grams lighter than white infants.

Despite such disparities in birth outcomes, much is already known about how to close these gaps and improve pregnancy outcomes for minority populations. Specific interventions--proven to be effective--can be implemented to overcome the problems of low-income women who receive insufficient prenatal care, who suffer from poor nutritional status and undue psychological and physical stress, and who practice poor health habits. This gap can be closed by applying what is already known about the risks of adverse pregnancy outcomes, improving the availability of data for minority populations and subpopulations, and pursuing a research agenda to further elucidate remaining disparities.

Table 4
Health Insurance Coverage for Women Aged 15-44
According to Type of Insurance,
by Race and Ethnicity, 1985

		Type of Insurance				
	Number	Private Group	Private Individual	Medicaid	Other Govt	None
	(000)	*(percent of women)*				
All women	56,152	67	10	9	4	17
White	42,949	72	11	5	4	15
Black	7,223	51	7	25	4	21
Hispanic	4,230	52	6	17	3	28
Other	1,750	59	10	9	8	20

Percentages may not add to 100 because women may have insurance from more than one source.

SOURCE: The Alan Guttmacher Institute.

DIFFERENCES WITHIN MINORITY POPULATIONS

Not only are there significant disparities among racial and ethnic groups, but also within such groups. This is particularly true for Hispanic and Asian populations. This section explores some of those differences for specific minority groups.[9]

Hispanics

Hispanics constitute the second largest minority population in the United States, second to blacks. As of March 1987, an estimated 18.8 million Hispanics resided in the U.S., consisting primarily of Mexicans (63 percent), Puerto Ricans (12 percent), Central and South Americans (11 percent), Cubans (5 percent), and other (8 percent).

Hispanics are distributed geographically according to their origin: 75 percent of California and Texas Hispanics are of Mexican origin, 60 percent of Florida Hispanics are of Cuban origin, and 50 percent of New York Hispanics are of Puerto Rican origin. Hispanics are also a diverse group. Generally, Puerto Ricans resemble blacks in family structure and infant outcome data, Cubans resemble white non-Hispanics, and Mexicans fall in between.

In 1985, 23 states and the District of Columbia reported 372,814 births of Hispanic parentage.[10] Because an estimated 92 percent of the Hispanic population in the United States resides in these states, the National Center for Health Statistics believes them to be representative of the Hispanic population in the United States The vast majority of births to Hispanic mothers, 95.4 percent in 1985, are classified as white. This varies by subgroup, however, from 87.2 percent for Central and South Americans to 98 percent for Mexicans.

Infant mortality statistics for Hispanics have been published annually since 1984 but are not comparable to national data for racial groups, as previously noted. As a result, caution is urged in generalizing these data to the entire Hispanic population of the United States.

Available data do indicate, however, that the Hispanic infant mortality rate is similar to the white rate, as shown in table 5, although the socioeconomic status is similar to blacks.

Explanations for the apparent favorable rate include a low incidence of low birthweight and a possible underreporting of infant deaths, par-

Table 5
Infant, Neonatal, and Postneonatal Mortality Rates
by Hispanic and Non-Hispanic Origin,
for 17 Reporting States [a] and the District of Columbia, 1985

	Infant Mortality	Neonatal Mortality	Postneonatal Mortality
	(Deaths per 1,000 live births)		
Hispanic (total)	8.6	5.4	3.2
Mexican	8.5	5.2	3.3
Puerto Rican	8.1	4.8	3.4
Cuban	7.6	6.3	1.3
Other [b]	8.9	6.0	2.9
Non-Hispanic (total)	10.2	6.5	3.7
White	8.9	5.7	3.2
Black	16.8	10.7	6.1

[a] *Arizona, Arkansas, California, Colorado, Georgia, Hawaii, Illinois, Indiana, Kansas, Mississippi, Nebraska, New York (including New York City), North Dakota, Ohio, Texas, Utah, and Wyoming.*

[b] *Includes Central and South American and other and unknown Hispanics.*

SOURCE: National Center for Health Statistics.

ticularly along the Mexican-American border region. Underreporting of neonatal deaths by Mexican nationals may occur because of fear of contact with government authorities, whereas birth registry is perceived as a way to assure residence and citizenship rights for the infant and parents.

Low birthweight data are more readily available than mortality data. Table 1 shows that, overall, birthweights for Hispanic infants are more similar to whites, except for Puerto Ricans, which are about midway between white and blacks.

Hispanic mothers begin prenatal care later than white non-Hispanic mothers. Overall, 61 percent of Hispanic mothers and black non-Hispanic mothers began prenatal care in the first trimester of pregnancy in 1985 compared with 82 percent of white non-Hispanic mothers. Figure 3 illustrates the differences among subgroups. Regardless of origin, teenage Hispanic mothers are more likely to receive delayed prenatal care or no care than are older mothers.

Although Hispanic mothers begin prenatal care later than white non-Hispanic mothers, the levels of low birthweight are comparable. It is difficult to account for this pattern, one that has been observed for several years. Even controlling for maternal age, onset of prenatal care, and maternal educational attainment showed the proportions of low birthweight infants still to be relatively favorable for Hispanic-origin, especially Mexican, babies.

One factor thought to be responsible for relatively good birth outcomes is the lower incidence of smoking among Hispanic than among non-Hispanic women. Other explanations include better nutrition, lower incidence of substance abuse, and maintenance of strong cultural norms that lend social support.

Asians

Asian Americans are the third largest and fastest growing minority group in the United States. In 1985, Asian births constituted about 3 percent of all births in the United States.

Asians are not a homogenous population, in many ways differing as much among themselves as from other races. Asians residing in the United States consist primarily of Chinese, Japanese, Hawaiian, and Filipino origin. Also included are Asian Indian, Cambodian, Korean, Laotian, and Vietnamese, as well as other Asian or Pacific Islanders. (In keeping with the National Center for Health Statistics' convention, "Asian" is used to describe the entire Asian and Pacific Islander population.)

In 1980, 58 percent of Asian mothers resided in western states. A majority of Asian mothers lived in three states: California (32 percent), Hawaii (16 percent), and New York (6 percent).

Asian mothers, with the exception of Hawaiians, are considerably older than either black or white mothers. In 1980, the median age of Asian mothers was 28 years (ranging from 29.4 for Chinese to 24.4 for Hawaiians), compared to 25.9 for whites and 24.2 for blacks. In addition, only 6 percent of Asian mothers were teenagers, compared with 14 percent of white mothers and 27 percent of black mothers.

The proportion of Asian mothers who had at least completed high school (80 percent) was nearly identical to whites (79 percent). The most striking difference was found for higher levels of education: 30 percent of Asians had completed 16 years or more of education, almost twice that for whites (16 percent) and five times that for blacks (6 percent).

Asian mothers are not as likely to start prenatal care in the first trimester of pregnancy and are more likely to delay care to the third trimester or to have no care than white mothers. In comparison with black mothers, however, care generally started far earlier, as shown in table 6. Among the Asian population, Japanese mothers are most likely to start care early and least likely to delay care or to have no care. The timing of prenatal care has been shown to be related to mothers' educational attainment. For all Asian groups, as educational attainment increases, women are more apt to start care earlier and less likely to have late or no care. This is generally true of all racial and ethnic groups.

As a group, birth outcomes for Asian women are favorable. On average, birthweight outcomes are more similar to whites than blacks (see table 1). Again, there are large differences among subgroups. For example, Chinese mothers tend to have the lowest incidence of low birthweight (5.0 percent), while Filipinos have the highest (6.9 percent).

Table 6
Percent distribution of Asian births by initiation of prenatal care and low birthweight, 1980

	Prenatal care		
	Early care[a]	Late or no care[b]	Low birth-weight[c]
	-------(percent distribution)-----		
Total Asians	74.7	6.2	6.5
Chinese	82.5	3.7	4.9
Japanese	86.1	2.2	6.2
Hawaiian	71.9	5.7	7.0
Filipino	77.8	4.0	7.4
Other	68.7	8.8	6.8
White	79.3	3.2	5.7
Black	62.7	8.8	12.5

[a] *Prenatal care began in the first trimester of pregnancy.*
[b] *Prenatal care began in the third trimester or not at all.*
[c] *Weight of less than 2,500 grams (5.5 pounds). See table 1 for more current (1985) data on low birthweight. Data for 1980 is included here for comparative purposes with initiation of prenatal care; such 1985 data for Asian subpopulations were unavailable.*

SOURCE: National Center for Health Statistics.

American Indians and Alaska Natives

Indian births represent about 1 percent of all births in the United States. The composite group of American Indians and Alaska Natives (which includes Eskimos, Aleuts, and other Indians residing in Alaska) is referred to as "Indian." However, significant differences exist between Alaska Natives and American Indians; differences can also be found between American Indians living in reservation and nonreservation areas.

In 1984, slightly more than half of all American Indian mothers resided in four states: Arizona and California (15 percent each), Oklahoma (13 percent), and New Mexico (9 percent). Minnesota, Montana, North Carolina, South Dakota, and Washington each accounted for 4 percent to 5 percent of American Indian births. Births to Alaska Natives represented 6 percent of all Indian births.

The Indian female population is generally younger than the white female population; in 1980, the median age of Indian females was 23.4 years compared with 32.5 years for white females. In 1984, one in five Indian mothers were teenagers (American Indians, 20 percent; Alaska Natives, 18 percent) compared to 11 percent for whites and 24 percent for blacks.

American Indian mothers are more likely than Alaska Native mothers to have less than 12 years of education (39 percent and 31 percent, respectively). As a group this was significantly higher than that of white mothers (18 percent), closer to that of black mothers (33 percent).

Delaying the start of prenatal care or receiving no prenatal care is more common among American Indians (13 percent) than Alaska Natives (9 percent). Indian mothers as a group are far more likely to start care late in pregnancy or to have no care than are white mothers. Their pattern of care is more similar to that of black, Mexican, and Puerto Rican mothers (see fig. 3).

Despite this pattern of care, the proportion of Indian infants that are of low birthweight compares favorably with that for white infants and is less than half that for black infants (see table 1). However, Indian infants were nearly 40 percent more likely than white infants to be born preterm (11 percent versus 8 percent), but one-third less likely than black infants (17 percent).

The favorable birthweight for Indian births compared with whites is unexpected in light of Indian mothers' lower educational attainment, younger ages, and relatively high proportion who are unmarried and start prenatal care late or not at all. Especially striking is the markedly lower incidence of low birthweight for unmarried teenagers who started care late. A higher incidence of diabetes among Indians, which results in larger-than-gestational-age birthweights, is believed to be at least partly responsible for this trend.

American Indians can be further analyzed according to whether or not they lived on reservations. The 1980 census showed that one-fourth of all Indians lived on reservations. Table 7 shows dif-

Table 7
Percent of Indian Mothers Residing in Reservation Areas by Selected Characteristics, 1984

	Mother's area of residence	
	Reservation	Non-reservation
	(percent)	
Under 20 years	21	20
Less than 12 years of school	41	36
Unmarried mothers	52	35
Prenatal care began in third trimester or no care	15	11
Low birthweight infants	5.6	6.4

SOURCE: National Center for Health Statistics.

ferences between these two American Indian subpopulations.

The 1985 infant mortality rate for Indians was 9.1, a rate less than the U.S. rate. The neonatal mortality rate was 4.2, considerably below the U.S. rate of 7.0 and even below the white rate of 6.1. (As previously discussed, this may be due to the underreporting of Indian infant deaths.) However, the postneonatal mortality rate was 5.0, significantly higher than the U.S. and white rates of 3.7 and 3.2, respectively. The limited data available reveal that excessive postneonatal deaths among Indian infants result from preventable accidents, such as injuries and poisonings, and treatable acute medical conditions, such as respiratory illnesses and intestinal infections. This suggests that Indian infants leave the hospital healthy but go home to unsafe environments. Apparently this is not unique to the United States; postneonatal mortality rates for Northwest Ontario Indians are reported to be four times the Canadian rate for all races.

The Indian Health Service, in collaboration with the American Academy of Pediatrics and the Centers for Disease Control, is intensively studying postneonatal infant mortality in selected areas. Risk factors in postneonatal infant mortality will be determined and used in establishing programs of intervention.

CONCLUSION

Citing a 1985 U.S. infant mortality rate of 10.6 per 1,000 live births masks the marked differences among and within America's various racial and ethnic groups. Maternal demographic characteristics and socioeconomic status bear strong relationships to birth outcomes. In our country, infant mortality and low birthweight rates are higher for young, uneducated, unmarried, nonwhite individuals with limited financial resources.

Given the many factors at play, improving birth outcomes of minority populations is a complex issue. In many areas, definitive studies do not even exist which examine the myriad factors that can affect these pregnancies. One solution will, therefore, not suffice.

Much is already known, however, about specific interventions which can be implemented to overcome the factors contributing to excessive infant mortality and low birthweight among minority populations. The disparities in birth outcomes between white and minority groups can be closed by applying what is already known about the risks of adverse pregnancy outcomes, improving the availability of data for minority groups and subgroups, and pursuing a research agenda to further elucidate remaining disparities. In combination, these can better assure that all women and infants in the United States have appropriate and timely health services leading to healthy birth outcomes, healthy children, and healthy futures.

NOTES

1. The National Vital Statistics System generally reports data by race in the categories of "white" and "all other," with the latter further broken into "total" and "black." Infant mortality data are also reported for other races, such as American Indians and Alaska Natives, Chinese, Japanese, Filipino, Other Asian or Pacific Islander, and Other. Ethnicity data, which is a different identifier than race, is reported by "Hispanic" and "Non-Hispanic" categories. Natality data for Hispanics is based on reporting by 23 states and the District of Columbia, whereas mortality data is generally based on reporting by 17 states and the District of Columbia.

2. See separate Issue Brief on "Low Birthweight," in this volume.

3. In 1980, the 17 reporting states and the District of Columbia accounted for about 77 percent of the U.S. Hispanic population, including about 89 percent of Mexicans, 66 percent of Puerto Ricans, 24 percent of Cubans, and 63 percent of other Hispanics.

4. For more detail on improving the collection of vital statistics data for the Hispanic population, see separate Issue Brief on "The National Vital Statistics System," in this volume.

5. This low infant mortality rate, however, may be a result of the underreporting of Indian infant deaths.

6. This section is largely based on Barbara N. Samuels, "Infant Mortality and Low Birth Weight Among Minority Groups in the United States: A Review of the Literature," in *Report of the Secretary's Task Force on Black and Minority Health*, January 1986.

7. See separate Issue Brief on "Low Birthweight," in this volume, for an explanation of how these risk factors affect pregnancy outcome.

8. For a more detailed discussion on health insurance coverage for women of childbearing age and infants, see separate Issue Brief on "The Financing of Maternal and Infant Care," in this volume.

9. One data problem for groups other than white or black is that infant mortality rates may be underestimated, on the basis of studies in which race on the birth and death certificates for the same infant were compared. On the birth certificate, race is reported by the mother at the time of delivery. On the death certificate, race of the deceased infant is reported by the funeral director on the basis of observation or on information supplied by someone else, such as a parent. It has been noted that many of these deaths are incorrectly classified as white.

10. For a discussion of the availability of infant birth and death statistics and recent initiatives to improve them, see Issue Brief on "The National Vital Statistics Program," in this volume.

REFERENCES

The Alan Guttmacher Institute, *The Financing of Maternity Care*, New York, December 1987.

Baldwin, Wendy, "Half Empty, Half Full: What We Know About Low Birth Weight Among Blacks," *Journal of the American Medical Association*, Vol. 255, No. 1, January 3, 1986.

Bureau of the Census, "The Hispanic Population in the United States: March 1986 and 1987 (Advance Report)," *Current Population Reports*, Population Characteristics, Series P-20, No. 416, August 1987.

Frost, Floyd and Kirkwood K. Shy, "Racial Differences between Linked Birth and Infant Death Records in Washington State," *American Journal of Public Health*, Vol. 70, No. 9, September 1980.

Honigfeld, Lisa S. and David W. Kaplan, "Native American Postneonatal Mortality," *Pediatrics*, Vol. 80, No. 4, October 1987.

Indian Health Service "Chart Series" Tables, Public Health Service, U.S. Department of Health and Human Services, February 22, 1988.

Kessel, Samuel S., et al., "Racial Differences in Pregnancy Outcomes," *Clinics in Perinatology, Current Controversies*, Spring 1988.

Kleinman, Joel C. and Samuel S. Kessel, "Racial Differences in Low Birth Weight: Trends and Factors," *The New England Journal of Medicine*, Vol. 317, No. 12, September 17, 1987.

Markides, Kyriakos S. and Jeannine Coreil, "The Health of Hispanics in the Southwestern United States: an Epidemiologic Paradox," *Public Health Reports*, Vol. 101, No. 3, May-June 1986.

Poma, Pedro, "Pregnancy in Hispanic Women," *Journal of the National Medical Association*, Vol. 79, No. 9, 1987.

National Center for Health Statistics, "Advance Report of Final Mortality Statistics, 1985," *Monthly Vital Statistics Report*, Vol. 36, No. 5, Supp. DHHS Pub. No. (PHS) 87-1120, Public Health Service, August 28, 1987.

National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1985," *Monthly Vital Statistics Report,* Vol. 36, No. 4, Supp. DHHS Pub. No. (PHS) 87-1120, Public Health Service, July 17, 1987.

National Center for Health Statistics, "Births of Hispanic Parentage, 1985," *Monthly Vital Statistics Report,* Vol. 36., No. 11, Supp. DHHS Pub. No. (PHS) 88-1120, Public Health Service, February 26, 1988.

National Center for Health Statistics, "Characteristics of American Indian and Alaska Native Births, United States, 1984," *Monthly Vital Statistics Report,* Vol. 36, No. 3, Supp. DHHS Pub. No. (PHS) 87-1120, Public Health Service, June 19, 1987.

National Center for Health Statistics, "Characteristics of Asian Births, United States, 1980," *Monthly Vital Statistics Report*, Vol. 36, No. 10, Supp. DHHS Pub. No. (PHS) 84-1120, Public Health Service, February 10, 1984.

National Center for Health Statistics, *Health, United States, 1987,* DHHS Pub. No. (PHS) 88-1232, Public Health Service, March 1988.

National Center for Health Statistics, *Vital Statistics of the United States, 1985,* Vol. II, Mortality, DHHS Publication No. (PHS) 88-1101, U.S. Department of Health and Human Services, Public Health Service, Hyattsville, Maryland, 1988.

U.S. Department of Health and Human Services, "Infant Mortality and Low Birthweight," Vol. VI, *Report of the Secretary's Task Force on Black & Minority Health,* January 1986.

U.S. Department of Health and Human Services, Public Health Service, Office of Disease Prevention and Health Promotion, *Disease Prevention/Health Promotion: The Facts,* 1988.

U.S. General Accounting Office, *Prenatal Care: Medicaid Recipients and Uninsured Women Obtain Insufficient Care,* GAO/HRD-87-137, September 1987.

ADOLESCENT PREGNANCY

ADOLESCENT PREGNANCY

A SUMMARY

- The percentage of 15 to 19 year old women who were sexually active before marriage increased from 28 percent in 1971 to 42 percent in 1982.
- In 1984, there were more than one million (1,004,859) teenage pregnancies in the United States, resulting in a teenage pregnancy rate of 109 pregnancies per 1,000 women aged 15 to 19.
- An estimated 4 out of every 10 teenage women become pregnant before they reach their twentieth birthday.
- In 1985, nearly 40 percent of all women who gave birth as a teenager had another child within 2 years.
- Between 1970 and 1984, the birth rate for unmarried 15 to 19 year olds increased 34.8 percent, from a rate of 22.4 in 1970 to a rate of 30.2 in 1984.
- Teens in the United States are not more sexually active than those of most other developed countries, but they have a higher rate of pregnancy and abortion.
- The infant mortality rate for mothers under the age of 17 is 18.0 per 1,000 live births, compared to 10.3 for mothers in their twenties.
- In 1985, only about half of all infants born to teenagers had mothers who received prenatal care in the first trimester, while about three-fourths of infants born to women of all ages had mothers who received early care.
- Mothers under the age of 18 have higher than average levels of pregnancy-related complications, such as toxemia, anemia, cervical trauma, and premature delivery.
- Because of the strong likelihood that they will drop out of school, teen mothers are at a great disadvantage for finding and keeping a job.
- In 1986, the United States spent $17.93 billion on all families that were begun by teen mothers. This number includes costs paid by Aid to Families With Dependent Children (AFDC), Medicaid, and food stamps.
- Strategies for preventing teen pregnancy include enhancing the life options of disadvantaged teenagers, assisting teens in delaying the initiation of sexual activity, and encouraging contraceptive use among sexually active teens.

ADOLESCENT PREGNANCY

Few problems cause greater concern for the health and well-being of our children than the incidence of adolescent pregnancy. The high level of sexual activity among teens, the increasing number of nonmarital births among teens, and the high rates of unintended pregnancy are causing growing concern among political and community leaders, as the health, social, and economic consequences of adolescent childbearing are becoming more and more apparent.

- In 1984, there were more than one million (1,004,859) teenage pregnancies in the United States, resulting in a teenage pregnancy rate of 109 pregnancies per 1,000 women aged 15 to 19.
- Of the total number of pregnant teens, 46.7 percent (469,682) gave birth, 40.0 percent (401,128) had abortions, and 13.3 percent (134,049) miscarried.
- An estimated 4 out of every 10 teenage women become pregnant before they reach their twentieth birthday.

Adolescent pregnancy has become a critical public policy issue because of the significant implications resulting from the fact that adolescent mothers are at greater risk for negative health, social, and economic problems than mothers who delay childbearing until after their teen years. In addition, when the pregnancy is unintended and the mother is not married at the time of the birth of her child, a teen mother is likely to experience these negative consequences to an even greater extent. In addition to age, several factors--including low income and low education level--also put an adolescent women at risk for negative consequences of pregnancy.

Strategies for preventing teenage pregnancy include enhancing the life options of disadvantaged teenagers, assisting teenagers in delaying the initiation of sexual activity, and encouraging contraceptive use among sexually active teenagers. For teens who have already become pregnant, actions can be taken to ensure that the mother and baby are healthy and to help prevent repeat pregnancies during the teen years.

TRENDS IN ADOLESCENT PREGNANCY AND CHILDBEARING

Several trends emphasize the need to address the problems associated with teenage pregnancy.

A high percentage of teenagers are sexually active. The percentage of 15 to 19 year old women who had sexual intercourse before marriage increased from 28 percent in 1971 to 46 percent in 1979. Although there are some difficulties with the data, it appears that since 1979, there has been a leveling off or possible slight decrease in the rates of sexual activity. However, in 1982, almost half of all teens (42 percent) were sexually active.

Teenage pregnancy rates have increased. The teen pregnancy rate per 1,000 women went from 94 in 1972 to 109 in 1984. Part of this increase reflects the fact that more teens were sexually active. Thus, when looking at the group of sexually active teens, as opposed to teenagers as a whole, the pregnancy rate among sexually active teens has declined slightly (from 272 per 1,000 sexually active women in 1972 to 233 per 1,000 sexually active women in 1984) due to a greater use of contraceptives. In addition, due to increased use of abortion, fewer teens are actually giving birth (66.2 percent in 1972 compared to 46.7 percent in 1984).

In contrast to the decline in birth rates among all teens, birth rates have not declined for unmarried and younger teens, two groups especially at high risk for negative consequences of childbearing. Between 1970 and 1984, the birth rate for unmarried 15 to 19 year olds increased 34.8 percent, from a rate of 22.4 in 1970 to a rate of 30.2 in 1984. Birth rates for teens less than 15 years old have virtually remained the same since the 1970s.

Black teens are more likely to have a non-marital birth. In 1984, the rate of non-marital childbearing among blacks was 87.1 per 1,000 unmarried black women aged 15 to 19. The comparable rate for whites was 19.0 per 1,000 unmarried white women.

However, the *increase* in non-marital teenage childbearing has been almost exclusively among whites. Non-marital birth rates for white teenage women 15 to 19 rose by 74 percent between 1970 and 1984. The rate of non-marital childbearing among blacks decreased by 10 percent during the same period.

Most teenage pregnancies are unintended. Over 80 percent of all pregnancies to females aged 15 to 19 are estimated to be unintended. Among girls under the age of 14, almost all pregnancies are estimated to be unintended. Teens whose pregnancies are unintended are less likely to obtain prenatal care, are less likely to complete their education, and are more likely to suffer negative social and economic consequences of early childbearing.

Adolescents who have their first baby as an unmarried teenager have a high likelihood of having a second baby within 2 years. In 1985, nearly 40 percent of all women who gave birth as a teenager had another child within 2 years.

PUBLIC PROGRAMS ADDRESSING THE NEEDS OF PREGNANT AND PARENTING TEENS

Federal programs provide funds directed toward preventing teenage pregnancy and addressing the problems associated with teenage childbearing. Currently, there is one federal program serving teenagers exclusively: the Adolescent Family Life (AFL) program, a national demonstration program under the Public Health Service Act. The goal of the $9.5 million program is to prevent teenage pregnancy through abstinence as well as to provide a range of health and social services to pregnant and parenting teenagers. The AFL program administers 88 demonstration projects throughout the nation.

The Family Planning Services program, funded under Title X of the Public Health Service Act, is another federal program available to teens. It is aimed toward helping to prevent unintended pregnancy by providing contraceptive and family planning services to the teen population, among others.

Three federal grant programs have pregnant and parenting teenagers as a target group: the Maternal and Child Health Services Block Grant; Employment Training Services for the Disadvantaged, part of the Job Training Partnership Act (JTPA); and the Special Supplemental Food Program for Women, Infants, and Children (WIC). Five federal programs provide services relevant to low-income pregnant and parenting teenagers: the Social Services Block Grant, the Community Health Center program, employment services and job training grants (under JTPA), child welfare grants, and Community Services Block Grants.

Other sources of federal support for teenage mothers and their children are Medicaid, Aid to Families with Dependent Children (AFDC), and food stamps. Of these, the largest source of public support to pregnant and parenting teens is the state-administered AFDC program. While teen parents constitute less than 10 percent of the yearly AFDC caseload, **more than half the women under 30 receiving AFDC support today became mothers when they were teenagers.**

States and some localities help administer and fund these federal programs and often contribute added resources of their own to provide additional support services for teenagers (beyond what is required by federal law).

IMPLICATIONS OF TEENAGE PREGNANCY

Adolescent parents, their infants, and society as a whole are affected by the negative consequences of teenage pregnancy because of the health, social, and economic implications involved with teenage childbearing. The consequences of teenage childbearing are difficult to document because of the complexity of factors affecting causes and outcomes. There is, however, growing evidence that some of the negative outcomes associated with teenage pregnancy and childbearing are a result of socioeconomic factors, such as poverty and low education level, that exist even without the teen pregnancy. Nevertheless, most people agree that teenage childbearing is associated with the following consequences.

Health

Most of the health risks involved with teenage pregnancy affect mothers under the age of 17, and especially under the age of 15. These women may not have reached physical maturity for childbearing and are less likely to obtain adequate prenatal care. They are at a higher risk for complications involving the health of the mother and her infant.

- Mothers aged 17 and under have higher than average levels of pregnancy-related complications such as toxemia, anemia, cervical trauma, and premature delivery.

- For teenagers under 15, the maternal mortality rate is 60 percent greater than for women in their twenties.

Babies born to teenage mothers have a greater risk of being born at low birthweight (less than 5 pounds, 8 ounces) which is a leading cause of infant mortality. Low birthweight is also associated with infant morbidity, babies who have physical or mental impairments possibly lasting throughout their lifetime.

- The infant mortality rate for mothers under the age of 17 is 18.0 per 1,000 live births compared to 10.3 for mothers in their twenties.

- Of all births to teen mothers in 1985, 9.3 percent were low birthweight, compared to 6.8 percent for all women.

Early and continuous prenatal care is the best way to ensure the health of the teen mother and her infant because it is the best way to prevent low birthweight, infant mortality, and infant morbidity. However, the younger the mother, the less likely she is to receive adequate prenatal care.

- In 1985, only about half of all infants born to teenagers had mothers who received prenatal care in the first trimester, while about two-thirds of infants born to women of all ages had mothers who received early care.

Research suggests that maternal age alone is not the determining factor in poor birth outcomes, except among the youngest teen mothers. Rather, other factors, such as receipt of prenatal care, socioeconomic characteristics of the mother (such as her education and income), and personal health habits (such as poor nutrition, smoking, or substance abuse), also have a great effect on the health of the mother and infant. Unfortunately, teenagers are at increased risk for many of these conditions.

Education and Employment

Adolescent mothers are less likely to finish high school than are non-parenting teens. In fact, adolescent pregnancy is one of the leading causes of school drop-outs. Of the women who became pregnant while in school but left before having a baby, 47 percent did not complete school. Of those who had their child while still in school, 36 percent did not complete their education. As is true with the population in general, teen mothers who have not completed high school are at a great disadvantage for finding and keeping a job and achieving economic security.

In addition to inadequate education, other factors make it difficult for teen mothers to become employed and economically self-sufficient. Teens are more likely to have larger families at shorter intervals than those who delay childbearing. Statistics show that as the number of children increases, fewer teen mothers are employed.

- Five years after delivery, 43 percent of teenage mothers with one child were employed steadily in the last 2 out of the 5 years, compared to 10 percent with two or more children.

●

In addition, because teen mothers complete less schooling on the whole, they are generally qualified only for jobs with lower status and lower pay. Taken together, this means that teen mothers are likely to have a smaller amount of money that will be needed to take care of a larger family. Furthermore, many teen mothers live in female-headed households with only one income to support their family. And, on average, women earn lower salaries than men and single women earn lower salaries than married women.

- In 1983, white married couples had a median income of $26,443, while white female-headed families had a median income of $13,498. During the same year, black married couples had a median income of $20,586, while the income for black female-headed families was $7,458.

And finally, teen fathers experience negative consequences of early parenthood as well as mothers. Adolescent fathers are likely to have a lower educational attainment, lower earnings, higher overall fertility, and higher divorce rates, compared to non-parenting young males.

Cost

The cost of teenage pregnancy and childbearing is usually estimated in terms of public expenditures for programs used by adolescent mothers. The Center for Population Options estimated that in 1986, the United States spent $17.93 billion of public money on all families that were begun by teenage mothers. This number includes costs paid by AFDC, Medicaid, and food stamps. The number does not include such services as housing, special education, foster care, day care, and other social services.

In addition, the Center reports that the average cost to the taxpayer for a family begun by a first birth to a teenage mother in 1986 will be $14,852 by the time the child reaches 20 years of age. *If this birth had been delayed until the mother was in her twenties, the United States would have saved $5,941 per birth,* in the costs of AFDC, Medicaid, food stamps, public housing, and social service costs.

Only one-third of teenage mothers receive public assistance. Among this group, the average cost to the public sector of a single birth to a teen who receives welfare is estimated to be $37,500 by the time the child reaches age 20.

Some states have also calculated the costs of teenage pregnancy. For example, the state of Illinois estimates that teenage pregnancy costs Illinois citizens $853 million a year. The greatest costs are for AFDC, Medicaid, child care for working teenage mothers, birth and newborn costs, and medical care for children not receiving public aid. Individuals pay 82 percent of this total in taxes for these programs or in out-of-pocket expenses. The remaining 18 percent is supported by revenue from taxes paid by the state's business sector.

STRATEGIES FOR ADDRESSING THE NEEDS OF PREGNANT AND PARENTING TEENS

Many factors place a teenager at risk for having negative consequences of early childbearing including age, education, poverty, and socioeconomic status. Although more research needs to be conducted, initial evidence points to the effectiveness of strategies for preventing adolescent pregnancy that address all of these factors in relationship to teen women and men.

Three predominant prevention strategies for reducing the rate and incidence of unintended adolescent pregnancy include enhancing life options of disadvantaged teenagers, assisting the teenager in delaying the initiation of sexual activity, and encouraging contraceptive use among sexually active teenagers. For teens who have already become pregnant, actions can be taken to ensure that the mother and baby are healthy and have access to support services and to help prevent repeat pregnancies during the teen years.

Enhancing Life Options of Disadvantaged Teenagers

Adolescents need a framework for understanding the consequences of sexual activity and teenage childbearing. For many high-risk teens, there are no disincentives to having a baby. According to the National Research Council,

> *"Inadequate basic skills, poor employment prospects, and the lack of successful role models for overcoming the overwhelmingly negative odds of intergenerational poverty have stifled the motivation of many to delay immediate gratification and avoid pregnancy."*

Life options education can provide the rationale for delaying pregnancy and the motivation to develop the skills necessary to complete one's education and to obtain a job. Approaches to developing decisionmaking skills and increasing the motivation for prevention include life planning courses, programs to improve school performance, employment programs (including community service), recreational programs, truancy and drop out prevention programs, and programs to provide positive role models for high risk teens.

Assisting the Teenager in Delaying the Initiation of Sexual Activity

Tremendous pressure is placed on teenagers today regarding sexual activity. Teenagers are constantly exposed to sexual messages in the media, in music, and from their peers. The high rate of sexual activity among teenagers, the possibility of sexually transmitted diseases including acquired immune deficiency syndrome (AIDS), and the high incidence of teenage pregnancy have furthered the effort to encourage teens to delay sexual activity.

Program strategies for delaying sexual activity include family life education, courses that teach assertiveness training and decisionmaking skills and, again, programs that provide positive role models to help counteract the negative messages that adolescents may receive.

Encouraging Contraceptive Use Among Sexually Active Teenagers

For teens who are already sexually active, many health, social, and economic problems may be prevented by reducing the number of unintended pregnancies. Access to contraceptive services for males and females will help achieve this goal. In fact, the National Research Council reports that current scientific evidence concludes that contraceptive use is the most effective means available for reducing unintended pregnancy. Research is beginning to indicate that these services may be more successful in combination with the prevention strategies discussed above.

Ensuring that Teen Mothers and Children Are Healthy and Helping to Prevent Repeat Pregnancies During the Teen Years

It is crucial that pregnant and parenting teens receive the health and medical care necessary to ensure a healthy pregnancy and birth. Good prenatal and medical care can help prevent infant mortality and later developmental problems associated with low birthweight. Many potential problems may be successfully treated if detected early in the pregnancy. In addition, the prenatal care provider can give important information about behavioral habits that might put a mother and her child's health at risk. The provider can also refer the teen mother to appropriate special support services, such as WIC services or counseling and community support groups.

Steps may also be taken to help prevent repeat teenage pregnancies and to give the mother the best chance of educational and economic security. Again, programs aimed at developing life options, helping the teen mother to complete her education, and assisting the mother in job training and child care are strategies that give the mother and her child the best chance of social and economic stability, especially for disadvantaged teen mothers.

School-Based Health Clinics

One frequently discussed strategy for reducing the incidence of adolescent pregnancy is the use of school-based or school-linked health clinics. These are clinics at or near junior and senior high schools that usually offer a variety of health services especially relevant to the needs of teenagers. Not all clinics offer the same services; however, typical services include physical examinations, treatment for minor illnesses and injuries, immunizations, sports physicals, preventive health services, family planning, pregnancy testing, mental health services, and screening for venereal disease. Some clinics offer additional services, including prenatal and postpartum care, day care, drug and alcohol abuse counseling, nutrition education, and many other services. The number of school-based clinics has increased from 23 clinics nationwide in 1984 to 126 as of the spring of 1988.

Although conclusive data are not available, some school-based and school-linked (clinics associated with the school but not on school grounds) clinics have shown encouraging results.

- After 20 months of exposure to school-linked clinic services in Baltimore, pregnancy rates among those using clinic services decreased by 22.5 percent, but rose by 39.5 percent among students not using clinic services.

- In the Baltimore program, the proportion of students who were sexually active declined in the program school over the course of the study.

CONCLUSION

Teenage pregnancy is a national problem that must be addressed on the federal, state, and local levels of government and by families and the community. Although research does not point to a proven approach to prevent teenage pregnancy, there are many examples of programs that seem to be working. These programs attempt to address the special health, social, and economic needs of adolescents.

By developing and refining what we do know about preventing teenage pregnancy and childbearing, we can take steps to ensure that our next generation has the best chance for being healthy and socially and economically successful.

REFERENCES

Center for Population Options, *Estimates of Public Costs for Teenage Childbearing, 1986 Report*, Washington, D.C., revised May 1987.

Center for Population Options, Fact Sheet, "Teenage Sexuality, Pregnancy, and Parenthood," Washington, D.C., April 1987.

Children's Defense Fund, *Teenage Pregnancy: An Advocate's Guide to the Numbers*, Washington, D.C., January/March 1988.

Children's Defense Fund, *The Health of America's Children: Maternal and Child Health Data Book*, Washington, D.C., 1988.

Jones, Elise, et al., "Teenage Pregnancy in Developed Countries: Determinants and Policy Implications," *Family Planning Perspectives*, Vol. 17, No. 2, March/April 1985.

Kenney, Asta M., "Teen Pregnancy: An Issue for Schools," *Phi Delta Kappan*, June 1987.

Lovick, Sharon R., *The School-Based Clinic Update 1987*, the Support Center for School-Based Clinics, Center for Population Options.

Mitchell, Faith and Claire Brindis, *Adolescent Pregnancy: The Responsibilities of Policymakers*, Pew Memorial Trust, Foundation for Health Services Research, Vol. 22, No. 6, August 1987.

National Research Council, *Risking the Future: Adolescent Sexuality, Pregnancy, and Childbearing*, National Academy Press, Washington, D.C., 1987.

Reis, Janet, *Teenage Pregnancy and Teenage Parenthood in Illinois: 1979-1983 Costs*, Center for Health Services and Policy Research, Northwestern University, Evanston, Illinois.

U.S. Congress, House of Representatives, Select Committee on Children, Youth, and Families, *Teen Pregnancy: What is Being Done? A State-By-State Look*, U.S. Government Printing Office, Washington, D.C., December 1985.

U.S. Congress, Office of Technology Assessment, *Healthy Children: Investing in the Future*, OTA-H-345, U.S. Government Printing Office, Washington, D.C., February 1988.

U.S. Department of Health & Human Services, Public Health Service, National Center for Health Statistics, "Advance Report of Final Natality Statistics, 1985", *Monthly Vital Statistics Report*, Vol. 36, No. 4, Supplement, July 17, 1987.

U.S. Department of Health and Human Services, Public Health Service, National Center for Health Statistics, *Linked Birth and Infant Death Record Project -Nine State Pilot Study*, Stage 1, 1982 Birth Cohort, Hyattsville, Maryland, November 1987.

U.S. General Accounting Office, *Teenage Pregnancy: 500,000 Births A Year But Few Tested Programs*, PEMD-86-16BR, Washington, D.C., July 1986.

Ventura, Stephanie J., Taffel, Selma M., amd William D. Mosher, "Estimates of Pregnancies and Pregnancy Rates for the United States, 1976-85," *American Journal of Public Health*, Vol. 78, No. 5, May 1988.

Wasem, Ruth Ellen and Sharon Stephan, *Teenage Pregnancy: Issues and Legislation*, IB8612B, U.S. Library of Congress, Congressional Research Service, Washington, D.C., April 1988.

THE NATIONAL VITAL STATISTICS PROGRAM

THE NATIONAL VITAL STATISTICS PROGRAM

A Summary

- The vital statistics of the United States--births, deaths, fetal deaths, marriages, and divorces and annulments--are the primary source of essential data about maternal and child health status.

- Vital statistics are collected and published through a decentralized, cooperative system. Registering vital events is the legal responsibility of the states.

- To make possible national reporting of vital statistics, the National Center for Health Statistics--in conjunction with the states--develops recommended standards in the form of model state laws and regulations, definitions, and reporting forms.

- The U.S. Standard Certificates of Live Birth, Death, and Fetal Death, revised about every 10 years, have recently been changed to provide for more complete and systematic data which will assist in maternal and child health planning. Recommended implementation of the revised certificates by the states is January 1, 1989.

- The extent to which the national vital statistics system will provide improved and more complete data relevant to infant mortality rates and the incidence of low birthweight is highly dependent on states' voluntary adoption of the new standard birth and death certificates.

- A national linked birth and infant death record file, currently under development, will provide important supplementary data on infant deaths which will make possible improved analysis of correlates of perinatal deaths and premature births. A national linked file, based on births that occurred in 1983, will be available by September 1988.

- Remaining enhancements of the national vital statistics reporting system to improve the quality of infant mortality statistics include shortening reporting lag times for final data, consistently defining and reporting fetal deaths, and improving the analytical capability of federal and state governments for the vast data that are collected.

THE NATIONAL VITAL STATISTICS PROGRAM

National data on infant mortality, the incidence of low birthweight, and other maternal and infant characteristics are available from the Department of Health and Human Services' National Center for Health Statistics (NCHS), which continuously collects and compiles data from birth and death certificates through the National Vital Statistics System. Infant mortality data--which are based on information reported on death certificates--are tabulated by age, race, Hispanic origin, sex, cause of death, and state. Low birthweight data, however, are based on birth certificate data and provide more detail: sex, race, and birth order of infant; parents' Hispanic origin; and mother's age, level of education, marital status, and receipt of prenatal care, among other things.

Supplemental information on birth outcomes is also provided through periodic special studies by NCHS, such as National Natality and Fetal Mortality Surveys, most recently completed in 1980. These include data on socioeconomic and demographic characteristics of mothers, prenatal care, pregnancy history, occupational background, health status of mother and infant, and types and sources of health care received.

Although the vital statistics system is the major source of national infant mortality data, it has not routinely and systematically captured all of the data needed to analyze the correlates of perinatal deaths and premature births in order to develop appropriate interventions. Initiatives underway to improve this include revising the U.S. standard birth and death certificates to better capture certain data, including Hispanic origin, and developing a national linked birth and infant death file. Remaining concerns about infant mortality statistics include reporting time lags in obtaining final data, lack of consistent reporting of fetal deaths, and the limited resources available for analysis by federal and state governments to fully analyze the vast data that are collected.

BACKGROUND

The vital statistics of the United States are collected and published through a decentralized, cooperative system between federal and state governments. Through the National Vital Statistics System, NCHS collects and publishes data on births, deaths, fetal deaths, marriages, divorces and annulments, and induced terminations of pregnancy. Collection of this information is the responsibility of the states and other registration areas, which include New York City, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and Guam.

Although the legal authority for registering vital events rests with the individual registration areas, cooperative efforts between federal and state governments make it possible to report national vital statistics data uniformly. This uniformity has been achieved by NCHS's periodic issuance of recommended standards and the cooperative adoption of these standards by the registration areas. These standards take the form of recommended laws and regulations (Model State Vital Statistics Act and Regulations), definitions (such as live birth and fetal death), and reporting forms (such as U.S. Standard Certificate of Live Birth and U.S. Standard Certificate of Death). States are not required, however, to use these standard registration forms.

States normally collect birth and death information for their own use and then provide a data tape with such information to NCHS. (A few states still provide data in the form of microfilm.) To offset the cost of producing the data tapes, states are provided federal funds through the vital statistics program.[1]

As part of this agreement, NCHS indicates those items of information it needs for the national vital statistics program, called a minimum basic data set. Each state is asked to provide these data items for national analysis. Because most states are able to provide this minimum data, NCHS is able to produce rather complete national vital statistics data.

NCHS produces annual vital statistics data for the United States and for states, counties, and other local areas, and monthly provisional data for the United States and each state. These are routinely published in the *Monthly Vital Statistics Report* and annual *Vital Statistics of the United States.* Two of the most commonly used reports are "Advance Report of Final Mortality Statistics" and "Advance Report of Final Natality Statistics," both part of the monthly vital statistics reporting series. Special reports are also completed on a periodic basis, such as for specific racial and ethnic groups.[2]

Supplemental information relevant to infant mortality and low birthweight by characteristics beyond that provided on birth and death certificates is available through special studies periodically conducted by NCHS. Based on questionnaires mailed to a national sample of mothers, physicians, hospitals, and other medical care providers, these surveys provide birth data by characteristics, such as mother's occupation and work history during pregnancy, father's occupation, source of health care for mother and infant, family income, mother's smoking and drinking habits, and whether the baby is breast or bottle fed. These have been conducted in the 1960s, 1972, and 1980. The 1988 National Maternal and Infant Health Survey, part of this series, is currently in process, with data collection expected to be completed in early 1990.

THE 1989 REVISIONS OF BIRTH AND DEATH CERTIFICATES

Every 10 years, federal and state officials work together to produce updated standard data collection forms, such as the standard birth and death certificates. The objective of the most recent revision--released by NCHS in December 1986 for implementation by states by January 1, 1989--was to develop certificates to meet the health data needs of the 1990s, balancing statistical considerations with the legal requirements of the vital statistics system. The 1989 U.S. Standard Certificate of Live Birth and the U.S. Standard Report of Fetal Death reflect major departures from previous revisions, reflecting an attempt to more systematically capture specific medical and ethnic data.[3]

The first and most obvious change is that a check-box format replaced open-ended medical questions. Under the new format, more than 20 specific medical risk factors are identified for reporting, including tobacco and alcohol use during pregnancy. Also included in the check-box format are complications of labor and/or delivery, obstetric procedures, method of delivery, congenital anomalies, and abnormal conditions of the newborn. These items can be used to monitor changing uses of technology in childbirth and to identify babies with specific abnormal conditions at birth.

Two items which were added to the fetal death report but not to the birth certificate are questions related to occupation and work industry of the mother and father. This data will be collected primarily to assess the impact of work-related environmental exposures on the fetus.

Another major modification to the standard certificates of birth, death, and fetal death is the addition of specific items to identify parents of Hispanic origin. The current lack of national data about the Hispanic population has received considerable attention. For example, infant mortality statistics for the Hispanic population were published for 1984 for the first time; yet these data are based primarily on 17 reporting states[4] and the District of Columbia, which accounted for about 77 percent of the U.S. Hispanic population in 1980.

Recommendations of various groups have addressed the need for uniform reporting of Hispanic origin on vital records. Revising the birth and death certificates to specifically include a designation of Hispanic origin responds to that need for more complete and uniform data. For those states with small Hispanic populations or with other significant ethnic groups, an alternative general ancestry item is available for use.

One new statistical item on the death certificate asks for the deceased person's level of education, intended to be an indicator of socioeconomic status.

States' adoption of the new standards

Although state adoption of these documents is voluntary, past experience has been good. But whether the prior high adoption rates can be maintained is unknown in view of the rather significant changes to the 1989 standards. For example, prior to 1988, only a few states made extensive use of check boxes; thus, it is difficult to predict the extent of compliance with the 1989 revisions.

One factor that may positively influence state acceptance is funding. NCHS is considering incorporating financial incentives to encourage state compliance. Another factor is training. Among other things, NCHS staff have developed and distributed booklets to states for use in training funeral home directors, medical staff, and others who will fill out the certificates.

The extent to which states will routinely collect data on Hispanic origin is unknown. Currently, 23 states[5] and the District of Columbia collect Hispanic natality data,[6] while 17 states and the District collect data which form the basis for Hispanic infant mortality data.[7] An NCHS official has estimated that at least an additional 10 states will collect such information in 1989. The collection of death certificate data on Hispanic origin has always been problematic, particularly from the some 40,000 funeral directors across the country who often seem reluctant to ask and specify such information. NCHS is particularly emphasizing the need to collect this data.

While reporting for Hispanics will probably improve, the same may not be true for other minority groups. For example, special studies have shown that infant deaths may be underreported for some races, such as American Indians, because of the failure to accurately record on the death certificate the race of the deceased infant. The extent to which this reporting will improve with the use of revised death certificate is unknown.

LINKED BIRTH AND INFANT DEATH RECORD PROJECT

The Linked Birth and Infant Death Record Project has been designed by NCHS to produce national data on infant deaths that has not been available nationally since the special study on births that occurred in 1980 (the National Infant Mortality Surveillance project). The current project is being conducted with a view toward incorporating national linked files as a routine part of the national vital statistics data system.

The linked record data system supplements information from the death certificate of an infant with information from the birth certificate including characteristics of the infant at birth, such as birthweight and gestational age, and characteristics of the mother, such as age, level of education, and marital status. The system will enable NCHS and the states to provide important information recommended by the World Health Organization on infant deaths, but not currently available from the death certificate. The system will comprise an important component of state and national data bases to study the correlates of perinatal deaths and premature births. Analyses under the new system can guide policy, program planning, and development of interventions to reduce infant mortality by targeting high-risk groups.

In stage one of the project, initiated in 1985, a linking methodology was developed and pilot tested in nine states.[8] Births which occurred in 1982 were included in the pilot test. In stage two, which began in 1986 and is still in process, the project was extended to all 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, and New York City. National linked files for births occurring in 1983 through 1986 will be produced. Results will lead to a national linked file of births and infant deaths as an integral part of the U.S. national vital statistics system.

The national linked file of 1983 births is projected for release by September 1988. This project is a joint endeavor of NCHS, the Office of the Assistant Secretary for Planning and Evaluation, the states, and the Association for Vital Records and Health Statistics.

REMAINING AREAS OF CONCERN

Revising the standard birth and death certificates and linking birth and infant death records are major initiatives which respond to two of the most commonly voiced shortcomings of the current vital statistics reporting system. Additional concerns, however, do remain.

Reporting time lags

While the lag time between end of calendar year and reporting of vital statistics data is shortening, considerable time still elapses before final data is available. Most recently, provisional data for 1987 was available just 3 months after the end of the year. But it still takes about 20 months for final data to be available. For example, the most recent final infant mortality data, published August 28, 1987, is for calendar year 1985.

One reason for this time lag is that significant variations still exist among states in terms of when they provide their data to NCHS; one state's tardiness can delay the entire reporting process. Additional federal funding to enhance state collection and reporting efforts could facilitate this process. Another factor is the time it takes NCHS to process the data once received.

No consistent reporting of fetal deaths

The definitions of live birth[9] and fetal death[10] currently recommended to the states by NCHS are recommended by the World Health Organization. States have definitions that are similar to --but not exactly the same as--these definitions. Reporting requirements also vary among states. For example:

- Forty-four (44) registration areas use the World Health Organization definition of live birth; 9 use a shortened version, 3 have no formal definition, and 1 specifies "of at least 20 weeks gestation" within the definition of live birth.

- All states require the reporting of a live birth regardless of length of gestation or weight, with one exception; one state requires the birth to be of at least 20 weeks gestation.

- Forty-two (42) registration areas use the suggested definition of fetal death; 13 use a shortened definition and 1 has no formal definition.

- State reporting requirements for fetal deaths fall into nine different categories, ranging from "all products of human conception" to "5 months of gestation" and variations which also consider weight. The majority, however, require reporting at least for fetal deaths of 20 weeks gestation or more.

NCHS recommends that fetal deaths of 20 weeks gestation or more or weight of 350 grams or more should be reported. This level was set to encourage states to collect data on fetal deaths to at least allow for analysis of national data beginning at 20 weeks gestation.

Standard definitions and reporting of fetal deaths are important in order to ensure consistent and comparable perinatal mortality data among states and even among countries. Enhancement of the vital statistics system to improve reporting of fetal deaths should receive high priority.

Limited analytical capability

Both federal and state governments, while able to collect considerable amounts of vital statistics events, are often unable to fully and adequately analyze the data due to resource constraints. Essentially, vital statistics are not considered a high priority issue and consequently often do not receive high priority in resources and funding. Yet this must be a high priority if there is to be high quality, timely data available from which to analyze the causes and correlates of infant mortality.

The observation and recommendation of the 1981 Select Panel on Child Health still holds true today:

"*. . .[W]e wish to stress our concern that much of the massive amounts of data already in hand in many agencies is inadequately analyzed and reported. The analytic staffs of these agencies are not large enough to do justice to these data given the continual pressures for the generation of new information. Therefore, we recommend that new funds be allocated for increased analytic staff as appropriate in agencies that collect significant amounts of health information.*" [11]

Additional data needs

Despite the data already available on birth outcomes, more is desired on a routine basis rather than by periodic, infrequent surveys. Additional suggested data needs include:

- Information on morbidity (illness) associated with low birthweight. No national data are currently available that systematically and routinely look at the relationship between low birthweight and subsequent morbidity.

- National birth-related data, such as birthweight and maternal characteristics, by income. The vital statistics reporting system does not collect information by income, making it difficult to determine the extent to which low birthweight is associated with poverty as distinct from other factors.

- National data that systematically and regularly link low birthweight data to participation in public programs such as the Special Supplemental Food Program for Women, Infants, and Children (WIC), Medicaid, Food Stamps, and Aid to Families with Dependent Children. This would be useful in evaluating the impact of public policies and programs. Some states, such as Missouri and Utah, are beginning to link such data.

- National data on maternity services women receive, including prenatal care and hospital delivery, based on insurance status. This would point out any variations in care based on whether women are uninsured, privately insured, or publicly insured.

CONCLUSION

Significant changes are in process for the national vital statistics reporting system which should enhance the quality of infant mortality statistics. These include revisions to the standard certificates of live births, deaths, and fetal deaths to improve the availability of medical data as well as ethnicity data. Linked birth and infant death records will also be instrumental in determining the correlates of perinatal deaths.

All states should be encouraged to adopt the new 1989 standard certificates and make a concerted effort to improve their reporting of birth and death certificate data, including training efforts for those responsible for collecting the data. Federal and state governments should also commit the necessary resources to produce timely, high quality vital statistics and to fully analyze the data collected. In so doing, they can better understand the correlates of infant mortality and develop appropriate interventions to improve the health status of mothers and children in this country.

NOTES

1. Federal funds cover about one-third of the state cost to produce the tapes. In fiscal year 1987, the federal share of such costs was $8.6 million, ranging from $37,837 for the Virgin Islands to $759,438 for California.

2. See reference section of the separate issue paper on "Minority Populations" for a listing of the most current available special reports for racial and ethnic groups.

3. The 1989 U.S. Standard Certificate of Live Birth, Death, and Report of Fetal Death are included as attachments to this paper.

4. Arizona, Arkansas, California, Colorado, Georgia, Hawaii, Illinois, Indiana, Kansas, Mississippi, Nebraska, New York (including New York City), North Dakota, Ohio, Texas, Utah, and Wyoming.

5. Florida, Maine, Nevada, New Jersey, New Mexico, and Tennessee, in addition to the 17 already listed.

6. Because an estimated 92 percent of the Hispanic population in the United States resides in these states, NCHS believes them to be representative of the Hispanic population in the United States.

7. Because these reporting areas account for only about three quarters of Hispanics, NCHS cautions about generalizing mortality patterns to the entire U.S. Hispanic population.

8. Illinois, Indiana, Massachusetts, Michigan, Missouri, New Hampshire, Texas, Vermont, and Wisconsin.

9. The World Health Organization defines live birth as the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of pregnancy, which, after such expulsion or extraction, breathes, or shows any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles, whether or not the umbilical cord has been cut or the placenta is attached.

10. The World Health Organization defines fetal death as death prior to the complete expulsion or extraction from its mother of a product of human conception, irrespective of the duration of the pregnancy; the death is indicated by the fact that after such expulsion or extraction the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles.

11. The Report of the Select Panel for the Promotion of Child Health, *Better Health For Our Children: A National Strategy*, Vol.1, Major Findings and Recommendations, p. 421.

REFERENCES

Freedman, Mary Anne, et al., "The 1989 Revisions of the U.S. Standard Certificates of Live Birth and Death and the U.S. Standard Report of Fetal Death," *American Journal of Public Health*, Vol. 78, No. 2, February 1988.

Frost, Floyd and Kirkwood K. Shy, "Racial Differences between Linked Birth and Infant Death Records in Washington State," *American Journal of Public Health*, Vol. 70, No. 9, September 1980.

Institute of Medicine, *Preventing Low Birthweight*, National Academy Press, Washington, D.C., 1985, pp. 275-78.

Kleinman, Joel, "Underreporting of Infant Deaths: Then and Now," *American Journal of Public Health*, Vol. 76, No. 4, April 1986.

"National Vital Statistics Program," a background paper provided by the Secretary of Health and Human Services to fellow members of the National Commission to Prevent Infant Mortality, April 25, 1988.

Prager, Kate, Glenn A. Flinchum, and David P. Johnson, "The NCHS Pilot Project to Link Birth and Infant Death Records: Stage 1," *Public Health Reports*, Vol. 102, No. 2, March-April, 1987.

Prager, Kate, et al., "Evaluation Report: Linked Birth and Infant Death Record Project, Nine-State Pilot Study, Stage 1, 1982 Birth Cohort," draft, National Center for Health Statistics, Hyattsville, Maryland, November 1987.

Prager, Kate, et al., "Preliminary Evaluation Report: Linked Birth and Infant Death Record Project, National Pilot Study, Stage 2, 1983 Birth Cohort," draft, National Center for Health Statistics, Hyattsville, Maryland, January 1988.

The Report of the Select Panel for the Promotion of Child Health, *Better Health For Our Children: A National Strategy*, Vol. 1, Major Findings and Recommendations, U.S. Department of Health and Human Services, Public Health Service, DHHS (PHS) Pub. No. 79-55071, 1981.

U.S. Department of Health and Human Services, "Infant Mortality and Low Birthweight," Vol. VI, *Report of the Secretary's Task Force on Black & Minority Health*, Washington, D.C., January 1986.

U.S. Department of Health and Human Services, Public Health Service, "National Center for Health Statistics," brochure, Hyattsville, Maryland, April 1987.

U.S. General Accounting Office, *Health and Nutrition: Collection of Vital Statistical Data on Hispanics*, GAO/HRD-88-68BR, March 1988.

TYPE/PRINT
IN
PERMANENT
BLACK INK
FOR
INSTRUCTIONS
SEE
HANDBOOK

U.S. STANDARD
CERTIFICATE OF LIVE BIRTH

LOCAL FILE NUMBER

BIRTH NUMBER

CHILD

1. CHILD'S NAME *(First,Middle,Last)*

2. DATE OF BIRTH *(Month,Day,Year)*

3. TIME OF BIRTH M

4. SEX

5. CITY, TOWN, OR LOCATION OF BIRTH

6. COUNTY OF BIRTH

7. PLACE OF BIRTH ☐ Hospital ☐ Freestanding Birthing Center ☐ Clinic/Doctor's Office ☐ Residence ☐ Other *(Specify)* ______

8. FACILITY NAME *(If not institution, give street and number)*

CERTIFIER ATTENDANT

9. I certify that this child was born alive at the place and time and on the date stated.

Signature ▶

10. DATE SIGNED *(Month,Day,Year)*

11. ATTENDANT'S NAME AND TITLE *(If other than certifier) (Type/Print)*

Name ______

☐ M.D ☐ D.O. ☐ C.N.M. ☐ Other Midwife

☐ Other *(Specify)* ______

12. CERTIFIER'S NAME AND TITLE *(Type/Print)*

Name ______

☐ M.D ☐ D.O. ☐ Hospital Admin. ☐ C.N.M. ☐ Other Midwife

☐ Other *(Specify)* ______

13. ATTENDANT'S MAILING ADDRESS *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*

DEATH UNDER ONE YEAR OF AGE
Enter State File Number of death certificate for this child

14. REGISTRAR'S SIGNATURE

▶

15. DATE FILED BY REGISTRAR *(Month,Day,Year)*

MOTHER

16a. MOTHER'S NAME *(First,Middle,Last)*

16b. MAIDEN SURNAME

17. DATE OF BIRTH *(Month,Day,Year)*

18. BIRTHPLACE *(State or Foreign Country)*

19a. RESIDENCE—STATE

19b. COUNTY

19c. CITY, TOWN, OR LOCATION

19d. STREET AND NUMBER

19e. INSIDE CITY LIMITS? *(Yes or no)*

20. MOTHER'S MAILING ADDRESS *(If same as residence, enter Zip Code only)*

FATHER

21. FATHER'S NAME *(First,Middle,Last)*

22. DATE OF BIRTH *(Month,Day,Year)*

23. BIRTHPLACE *(State or Foreign Country)*

INFORMANT

24. I certify that the personal information provided on this certificate is correct to the best of my knowledge and belief.

Signature of Parent or Other Informant ▶

INFORMATION FOR MEDICAL AND HEALTH USE ONLY

	25. OF HISPANIC ORIGIN? *(Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.)*	26. RACE—American Indian, Black, White, etc. *(Specify below)*	27. EDUCATION *(Specify only highest grade completed)* Elementary/Secondary (0-12)	College (1-4 or 5+)
MOTHER	25a. ☐ No ☐ Yes Specify	26a.	27a.	
FATHER	25b. ☐ No ☐ Yes Specify	26b.	27b.	

28. PREGNANCY HISTORY *(Complete each section)*

LIVE BIRTHS *(Do not include this child)*

28a. Now Living — Number ______ ☐ None

28b. Now Dead — Number ______ ☐ None

28c. DATE OF LAST LIVE BIRTH *(Month,Year)*

OTHER TERMINATIONS *(Spontaneous and induced at any time after conception)*

28d. Number ______ ☐ None

28e. DATE OF LAST OTHER TERMINATION *(Month,Year)*

29. MOTHER MARRIED? *(At birth, conception, or any time between) (Yes or no)*

30. DATE LAST NORMAL MENSES BEGAN *(Month,Day,Year)*

31. MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. *(Specify)*

32. PRENATAL VISITS—Total Number *(If none, so state)*

33. BIRTH WEIGHT *(Specify unit)*

34. CLINICAL ESTIMATE OF GESTATION *(Weeks)*

35a. PLURALITY—Single, Twin, Triplet, etc. *(Specify)*

35b. IF NOT SINGLE BIRTH—Born First, Second, Third, etc. *(Specify)*

MULTIPLE BIRTHS
Enter State File Number for Mate(s)
LIVE BIRTH(S)

FETAL DEATH(S)

36. APGAR SCORE

36a. 1 Minute

36b. 5 Minutes

37a. MOTHER TRANSFERRED PRIOR TO DELIVERY? ☐ No ☐ Yes If Yes, enter name of facility transferred from:

37b. INFANT TRANSFERRED? ☐ No ☐ Yes If Yes, enter name of facility transferred to:

38a. MEDICAL RISK FACTORS FOR THIS PREGNANCY *(Check all that apply)*

Anemia (Hct. < 30/Hgb. < 10)	01	☐
Cardiac disease	02	☐
Acute or chronic lung disease	03	☐
Diabetes	04	☐
Genital herpes	05	☐
Hydramnios/Oligohydramnios	06	☐
Hemoglobinopathy	07	☐
Hypertension, chronic	08	☐
Hypertension, pregnancy-associated	09	☐
Eclampsia	10	☐
Incompetent cervix	11	☐
Previous infant 4000+ grams	12	☐
Previous preterm or small-for-gestational-age infant	13	☐
Renal disease	14	☐
Rh sensitization	15	☐
Uterine bleeding	16	☐
None	00	☐
Other ______ *(Specify)*	17	☐

38b. OTHER RISK FACTORS FOR THIS PREGNANCY *(Complete all items)*

Tobacco use during pregnancy .... Yes ☐ No ☐
Average number cigarettes per day ______
Alcohol use during pregnancy .... Yes ☐ No ☐
Average number drinks per week ______
Weight gained during pregnancy ______ lbs.

39. OBSTETRIC PROCEDURES *(Check all that apply)*

Amniocentesis	01	☐
Electronic fetal monitoring	02	☐
Induction of labor	03	☐
Stimulation of labor	04	☐
Tocolysis	05	☐
Ultrasound	06	☐
None	00	☐
Other ______ *(Specify)*	07	☐

40. COMPLICATIONS OF LABOR AND/OR DELIVERY *(Check all that apply)*

Febrile (> 100°F. or 38°C.)	01	☐
Meconium, moderate/heavy	02	☐
Premature rupture of membrane (> 12 hours)	03	☐
Abruptio placenta	04	☐
Placenta previa	05	☐
Other excessive bleeding	06	☐
Seizures during labor	07	☐
Precipitous labor (< 3 hours)	08	☐
Prolonged labor (> 20 hours)	09	☐
Dysfunctional labor	10	☐
Breech/Malpresentation	11	☐
Cephalopelvic disproportion	12	☐
Cord prolapse	13	☐
Anesthetic complications	14	☐
Fetal distress	15	☐
None	00	☐
Other ______ *(Specify)*	16	☐

41. METHOD OF DELIVERY *(Check all that apply)*

Vaginal	01	☐
Vaginal birth after previous C-section	02	☐
Primary C-section	03	☐
Repeat C-section	04	☐
Forceps	05	☐
Vacuum	06	☐

42. ABNORMAL CONDITIONS OF THE NEWBORN *(Check all that apply)*

Anemia (Hct. < 39/Hgb. < 13)	01	☐
Birth injury	02	☐
Fetal alcohol syndrome	03	☐
Hyaline membrane disease/RDS	04	☐
Meconium aspiration syndrome	05	☐
Assisted ventilation < 30 min	06	☐
Assisted ventilation ≥ 30 min	07	☐
Seizures	08	☐
None	00	☐
Other ______ *(Specify)*	09	☐

43. CONGENITAL ANOMALIES OF CHILD *(Check all that apply)*

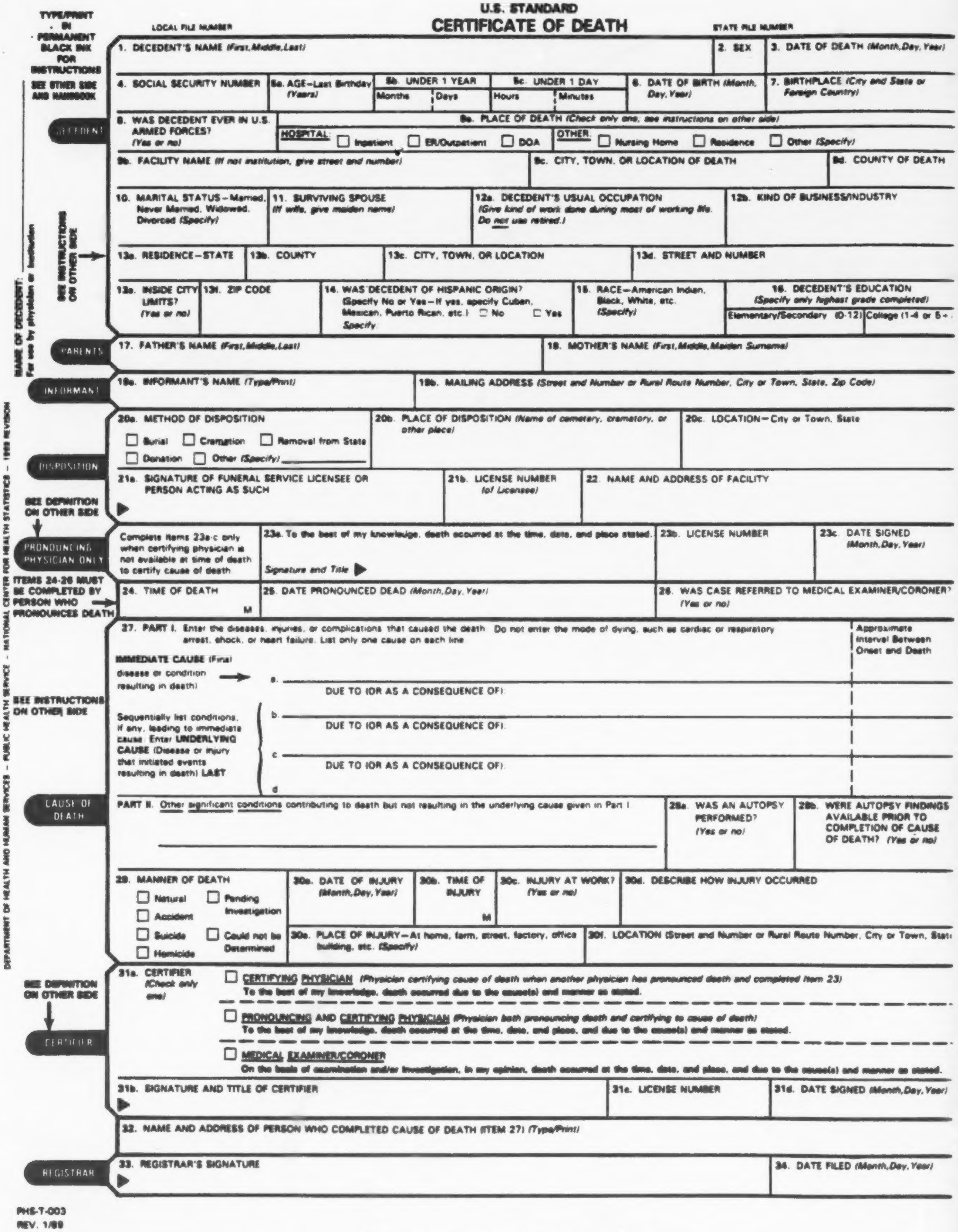
Anencephalus	01	☐
Spina bifida/Meningocele	02	☐
Hydrocephalus	03	☐
Microcephalus	04	☐
Other central nervous system anomalies *(Specify)* ______	05	☐
Heart malformations	06	☐
Other circulatory/respiratory anomalies *(Specify)* ______	07	☐
Rectal atresia/stenosis	08	☐
Tracheo-esophageal fistula/Esophageal atresia	09	☐
Omphalocele/Gastroschisis	10	☐
Other gastrointestinal anomalies *(Specify)* ______	11	☐
Malformed genitalia	12	☐
Renal agenesis	13	☐
Other urogenital anomalies *(Specify)* ______	14	☐
Cleft lip/palate	15	☐
Polydactyly/Syndactyly/Adactyly	16	☐
Club foot	17	☐
Diaphragmatic hernia	18	☐
Other musculoskeletal/integumental anomalies *(Specify)* ______	19	☐
Down's syndrome	20	☐
Other chromosomal anomalies *(Specify)* ______	21	☐
None	00	☐
Other ______ *(Specify)*	22	☐

DEPARTMENT OF HEALTH AND HUMAN SERVICES - PUBLIC HEALTH SERVICE - NATIONAL CENTER FOR HEALTH STATISTICS - 1989 REVISION

PHS-T-003
REV. 1/89

BEST COPY AVAILABLE

Actual size is 8½ x 14



TYPE/PRINT IN PERMANENT BLACK INK FOR INSTRUCTIONS SEE OTHER SIDE AND HANDBOOK

LOCAL FILE NUMBER

U.S. STANDARD
CERTIFICATE OF DEATH

STATE FILE NUMBER

DECEDENT

1. DECEDENT'S NAME *(First,Middle,Last)*
2. SEX
3. DATE OF DEATH *(Month,Day,Year)*
4. SOCIAL SECURITY NUMBER
5a. AGE—Last Birthday *(Years)*
5b. UNDER 1 YEAR: Months | Days
5c. UNDER 1 DAY: Hours | Minutes
6. DATE OF BIRTH *(Month, Day, Year)*
7. BIRTHPLACE *(City and State or Foreign Country)*
8. WAS DECEDENT EVER IN U.S. ARMED FORCES? *(Yes or no)*
9a. PLACE OF DEATH *(Check only one; see instructions on other side)*
HOSPITAL: ☐ Inpatient ☐ ER/Outpatient ☐ DOA
OTHER: ☐ Nursing Home ☐ Residence ☐ Other *(Specify)*
9b. FACILITY NAME *(If not institution, give street and number)*
9c. CITY, TOWN, OR LOCATION OF DEATH
9d. COUNTY OF DEATH
10. MARITAL STATUS—Married, Never Married, Widowed, Divorced *(Specify)*
11. SURVIVING SPOUSE *(If wife, give maiden name)*
12a. DECEDENT'S USUAL OCCUPATION *(Give kind of work done during most of working life. Do not use retired.)*
12b. KIND OF BUSINESS/INDUSTRY

SEE INSTRUCTIONS ON OTHER SIDE →

13a. RESIDENCE—STATE
13b. COUNTY
13c. CITY, TOWN, OR LOCATION
13d. STREET AND NUMBER
13e. INSIDE CITY LIMITS? *(Yes or no)*
13f. ZIP CODE
14. WAS DECEDENT OF HISPANIC ORIGIN? (Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.) ☐ No ☐ Yes *Specify:*
15. RACE—American Indian, Black, White, etc. *(Specify)*
16. DECEDENT'S EDUCATION *(Specify only highest grade completed)*: Elementary/Secondary (0-12) | College (1-4 or 5+)

NAME OF DECEDENT: ________
For use by physician or institution

PARENTS

17. FATHER'S NAME *(First,Middle,Last)*
18. MOTHER'S NAME *(First,Middle,Maiden Surname)*

INFORMANT

19a. INFORMANT'S NAME *(Type/Print)*
19b. MAILING ADDRESS *(Street and Number or Rural Route Number, City or Town, State, Zip Code)*

DISPOSITION

20a. METHOD OF DISPOSITION
☐ Burial ☐ Cremation ☐ Removal from State
☐ Donation ☐ Other *(Specify)* ________
20b. PLACE OF DISPOSITION *(Name of cemetery, crematory, or other place)*
20c. LOCATION—City or Town, State
21a. SIGNATURE OF FUNERAL SERVICE LICENSEE OR PERSON ACTING AS SUCH ▶
21b. LICENSE NUMBER *(of Licensee)*
22. NAME AND ADDRESS OF FACILITY

SEE DEFINITION ON OTHER SIDE ↓

PRONOUNCING PHYSICIAN ONLY

Complete items 23a-c only when certifying physician is not available at time of death to certify cause of death

23a. To the best of my knowledge, death occurred at the time, date, and place stated. *Signature and Title* ▶
23b. LICENSE NUMBER
23c. DATE SIGNED *(Month,Day,Year)*

ITEMS 24-26 MUST BE COMPLETED BY PERSON WHO PRONOUNCES DEATH →

24. TIME OF DEATH ________ M
25. DATE PRONOUNCED DEAD *(Month,Day,Year)*
26. WAS CASE REFERRED TO MEDICAL EXAMINER/CORONER? *(Yes or no)*

CAUSE OF DEATH

SEE INSTRUCTIONS ON OTHER SIDE

27. PART I. Enter the diseases, injuries, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Approximate Interval Between Onset and Death

IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ________

DUE TO (OR AS A CONSEQUENCE OF):

Sequentially list conditions, if any, leading to immediate cause. Enter **UNDERLYING CAUSE** (Disease or injury that initiated events resulting in death) **LAST**

b. ________

DUE TO (OR AS A CONSEQUENCE OF):

c. ________

DUE TO (OR AS A CONSEQUENCE OF):

d. ________

PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

28a. WAS AN AUTOPSY PERFORMED? *(Yes or no)*
28b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? *(Yes or no)*
29. MANNER OF DEATH
☐ Natural ☐ Pending Investigation
☐ Accident
☐ Suicide ☐ Could not be Determined
☐ Homicide
30a. DATE OF INJURY *(Month,Day,Year)*
30b. TIME OF INJURY ________ M
30c. INJURY AT WORK? *(Yes or no)*
30d. DESCRIBE HOW INJURY OCCURRED
30e. PLACE OF INJURY—At home, farm, street, factory, office building, etc. *(Specify)*
30f. LOCATION (Street and Number or Rural Route Number, City or Town, State)

SEE DEFINITION ON OTHER SIDE ↓

CERTIFIER

31a. CERTIFIER *(Check only one)*

☐ CERTIFYING PHYSICIAN *(Physician certifying cause of death when another physician has pronounced death and completed item 23)*
To the best of my knowledge, death occurred due to the cause(s) and manner as stated.

☐ PRONOUNCING AND CERTIFYING PHYSICIAN *(Physician both pronouncing death and certifying to cause of death)*
To the best of my knowledge, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

☐ MEDICAL EXAMINER/CORONER
On the basis of examination and/or investigation, in my opinion, death occurred at the time, date, and place, and due to the cause(s) and manner as stated.

31b. SIGNATURE AND TITLE OF CERTIFIER ▶
31c. LICENSE NUMBER
31d. DATE SIGNED *(Month,Day,Year)*
32. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) *(Type/Print)*

REGISTRAR

33. REGISTRAR'S SIGNATURE ▶
34. DATE FILED *(Month,Day,Year)*

DEPARTMENT OF HEALTH AND HUMAN SERVICES — PUBLIC HEALTH SERVICE — NATIONAL CENTER FOR HEALTH STATISTICS — 1989 REVISION

PHS-T-003
REV. 1/89

Actual size is 8½ x 11

BEST COPY AVAILABLE

TYPE/PRINT IN PERMANENT BLACK INK
FOR INSTRUCTIONS SEE HANDBOOK

U.S. STANDARD
REPORT OF FETAL DEATH

STATE FILE NUMBER

1. FACILITY NAME *(If not institution, give street and number)*			
2. CITY, TOWN, OR LOCATION OF DELIVERY	3. COUNTY OF DELIVERY	4. DATE OF DELIVERY *(Month,Day,Year)*	5. SEX OF FETUS
6a. MOTHER'S NAME *(First,Middle,Last)*	6b. MAIDEN SURNAME	7. DATE OF BIRTH *(Month,Day,Year)*	
8a. RESIDENCE-STATE	8b. COUNTY	8c. CITY, TOWN, OR LOCATION	8d. STREET AND NUMBER
8e. INSIDE CITY LIMITS? *(Yes or no)*	8f. ZIP CODE	9. FATHER'S NAME *(First,Middle,Last)*	10. DATE OF BIRTH *(Month,Day,Year)*

11. OF HISPANIC ORIGIN? *(Specify No or Yes—If yes, specify Cuban, Mexican, Puerto Rican, etc.)*	12. RACE—American Indian, Black, White, etc. *(Specify below)*	13. EDUCATION *(Specify only highest grade completed)* Elementary/Secondary (0-12)	College (1-4 or 5+)	14. OCCUPATION AND BUSINESS/INDUSTRY *(Worked during last year)* Occupation	Business/Industry
11a. ☐ No ☐ Yes Specify:	12a.	13a.		14a.	14b.
11b. ☐ No ☐ Yes Specify:	12b.	13b.		14c.	14d.

MULTIPLE BIRTHS
Enter State File Number for Mate(s)
LIVE BIRTH(S)

FETAL DEATH(S)

15. PREGNANCY HISTORY *(Complete each section)*

LIVE BIRTHS		OTHER TERMINATIONS *(Spontaneous and induced at any time after conception)*
15a. Now Living Number ____ ☐ None	15b. Now Dead Number ____ ☐ None	15d. *(Do not include this fetus)* Number ____ ☐ None
15c. DATE OF LAST LIVE BIRTH *(Month, Year)*		15e. DATE OF LAST OTHER TERMINATION *(Month, Year)*

16. MOTHER MARRIED? (At delivery, conception, or any time between) *(Yes or no)*	17. DATE LAST NORMAL MENSES BEGAN *(Month,Day,Year)*
18. MONTH OF PREGNANCY PRENATAL CARE BEGAN—First, Second, Third, etc. *(Specify)*	19. PRENATAL VISITS—Total Number *(If none, so state)*
20. WEIGHT OF FETUS *(Specify Unit)*	21. CLINICAL ESTIMATE OF GESTATION *(Weeks)*
22a. PLURALITY—Single, Twin, Triplet, etc. *(Specify)*	22b. IF NOT SINGLE BIRTH—Born First, Second, Third, etc. *(Specify)*

23a. MEDICAL RISK FACTORS FOR THIS PREGNANCY *(Check all that apply)*

Anemia (Hct. < 30/Hgb < 10) .... 01 ☐
Cardiac disease .... 02 ☐
Acute or chronic lung disease .... 03 ☐
Diabetes .... 04 ☐
Genital herpes .... 05 ☐
Hydramnios/Oligohydramnios .... 06 ☐
Hemoglobinopathy .... 07 ☐
Hypertension, chronic .... 08 ☐
Hypertension, pregnancy-associated .... 09 ☐
Eclampsia .... 10 ☐
Incompetent cervix .... 11 ☐
Previous infant 4000+ grams .... 12 ☐
Previous preterm or small-for-gestational-age infant .... 13 ☐
Renal disease .... 14 ☐
Rh sensitization .... 15 ☐
Uterine bleeding .... 16 ☐
None .... 00 ☐
Other ____________ 17 ☐
(Specify)

23b. OTHER RISK FACTORS FOR THIS PREGNANCY *(Complete all items)*

Tobacco use during pregnancy .... Yes ☐ No ☐
Average number cigarettes per day ____
Alcohol use during pregnancy .... Yes ☐ No ☐
Average number drinks per week ____
Weight gained during pregnancy ______ lbs.

24. OBSTETRIC PROCEDURES *(Check all that apply)*

Amniocentesis .... 01 ☐
Electronic fetal monitoring .... 02 ☐
Induction of labor .... 03 ☐
Stimulation of labor .... 04 ☐
Tocolysis .... 05 ☐
Ultrasound .... 06 ☐
None .... 00 ☐
Other ____________ 07 ☐
(Specify)

25. COMPLICATIONS OF LABOR AND/OR DELIVERY *(Check all that apply)*

Febrile (>100°F. or 38°C.) .... 01 ☐
Meconium, moderate/heavy .... 02 ☐
Premature rupture of membrane (>12 hours) .... 03 ☐
Abruptio placenta .... 04 ☐
Placenta previa .... 05 ☐
Other excessive bleeding .... 06 ☐
Seizures during labor .... 07 ☐
Precipitous labor (< 3 hours) .... 08 ☐
Prolonged labor (>20 hours) .... 09 ☐
Dysfunctional labor .... 10 ☐
Breech/Malpresentation .... 11 ☐
Cephalopelvic disproportion .... 12 ☐
Cord prolapse .... 13 ☐
Anesthetic complications .... 14 ☐
Fetal distress .... 15 ☐
None .... 00 ☐
Other ____________ 16 ☐
(Specify)

26. METHOD OF DELIVERY *(Check all that apply)*

Vaginal .... 01 ☐
Vaginal birth after previous C-section .... 02 ☐
Primary C-section .... 03 ☐
Repeat C-section .... 04 ☐
Forceps .... 05 ☐
Vacuum .... 06 ☐
Hysterotomy/Hysterectomy .... 07 ☐

27. CONGENITAL ANOMALIES OF FETUS *(Check all that apply)*

Anencephalus .... 01 ☐
Spina bifida/Meningocele .... 02 ☐
Hydrocephalus .... 03 ☐
Microcephalus .... 04 ☐
Other central nervous system anomalies
(Specify) ____________ 05 ☐
Heart malformations .... 06 ☐
Other circulatory/respiratory anomalies
(Specify) ____________ 07 ☐
Rectal atresia/stenosis .... 08 ☐
Tracheo-esophageal fistula/Esophageal atresia .... 09 ☐
Omphalocele/Gastroschisis .... 10 ☐
Other gastrointestinal anomalies
(Specify) ____________ 11 ☐
Malformed genitalia .... 12 ☐
Renal agenesis .... 13 ☐
Other urogenital anomalies
(Specify) ____________ 14 ☐
Cleft lip/palate .... 15 ☐
Polydactyly/Syndactyly/Adactyly .... 16 ☐
Club foot .... 17 ☐
Diaphragmatic hernia .... 18 ☐
Other musculoskeletal/integumental anomalies
(Specify) ____________ 19 ☐
Down's syndrome .... 20 ☐
Other chromosomal anomalies
(Specify) ____________ 21 ☐
None .... 00 ☐
Other ____________ 22 ☐
(Specify)

28. Enter only one cause per line for a, b, and c.

PART I. Fetal or maternal condition directly causing fetal death. — IMMEDIATE CAUSE
a. ______________________ Specify Fetal or Maternal
DUE TO (OR AS A CONSEQUENCE OF):
Fetal and/or maternal conditions, if any, giving rise to the immediate cause(s), stating the underlying cause last.
b. ______________________ Specify Fetal or Maternal
DUE TO (OR AS A CONSEQUENCE OF):
c. ______________________ Specify Fetal or Maternal

PART II. Other significant conditions of fetus or mother contributing to fetal death but not resulting in the underlying cause given in Part I.
____
____

29. FETUS DIED BEFORE LABOR, DURING LABOR OR DELIVERY, UNKNOWN *(Specify)*

30. ATTENDANT'S NAME AND TITLE *(Type/Print)*
Name ______________________
☐ M.D. ☐ D.O. ☐ C.N.M. ☐ Other Midwife
☐ Other *(Specify)* ______________________

31. NAME AND TITLE OF PERSON COMPLETING REPORT *(Type/Print)*
Name ______________________
Title ______________________

DEPARTMENT OF HEALTH AND HUMAN SERVICES – PUBLIC HEALTH SERVICE – NATIONAL CENTER FOR HEALTH STATISTICS – 1989 REVISION

PHS-T-007
REV. 1/89

actual size is 8½ x 14 BEST COPY AVAILABLE

The National Commission to Prevent Infant Mortality

The National Commission to Prevent Infant Mortality was created by Congress (P.L. 99-660) and established on July 1, 1987. The fifteen members of the Commission include Members of Congress, the Secretary of Health and Human Services, the Comptroller General of the United States, representatives of state governments, and experts in the maternal and child health field. Through a series of public hearings and meetings, a review of current federal and state programs and policies affecting the health of childbearing women and their infants, and an examination of private health care financing systems for the health care of these individuals, the Commission developed a national strategy for reducing infant mortality in the United States. The Commission's report to the President and Congress, entitled *Death Before Life: The Tragedy of Infant Mortality* (August 1988), recommends action steps that the public and private sectors can take to achieve this goal.

List of Members

The Honorable Lawton Chiles, Chairman
United States Senator
Washington, D.C.

The Honorable J. Roy Rowland, Vice Chairman
Member of Congress
Washington, D.C.

The Honorable Otis R. Bowen, M.D.
Secretary of Health and Human Services
Washington, D.C.

The Honorable Charles A. Bowsher
Comptroller General of the United States
Washington, D.C.

The Honorable David F. Durenberger
United States Senator
Washington, D.C.

Herman A. Hein, M.D.
Professor of Pediatrics
University of Iowa
Iowa City, Iowa

William Hollinshead, III, M.D., M.P.H.
Medical Director and Chief
Division of Family Health
Rhode Island Department of Health
Providence, Rhode Island

Barbara D. Matula
Director, Division of Medical Assistance
Department of Human Resources
Raleigh, North Carolina

Julius Richmond, M.D.
Division of Health Policy Research and Education
Harvard University
Boston, Massachusetts

The Honorable Richard W. Riley
Columbia, South Carolina

Lynda Johnson Robb
Washington, D.C.

The Honorable Thomas J. Tauke
Member of Congress
Washington, D.C.

The Honorable James R. Thompson
Governor
Springfield, Illinois

The Honorable Diane E. Watson
State Senator
Sacramento, California

Margaret S. Wilson
Executive Dean
Eastern Connecticut State University
Norwich, Connecticut

Rae K. Grad, R.N., Ph.D.
Executive Director

The National Commission to Prevent Infant Mortality

Switzer Building
Room 2006
330 C Street, S.W.
Washington, D.C. 20201
(202) 472-1364

BEST COPY AVAILABLE

Testimonies to the National Commission to Prevent Infant Mortality

Fourth National Hearing

Chicago, IL

April 25, 1988

U.S. DEPARTMENT OF EDUCATION
Office of Educational Research and Improvement
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

This document has been reproduced as received from the person or organization originating it

☐ Minor changes have been made to improve reproduction quality

- Points of view or opinions stated in this document do not necessarily represent official OERI position or policy

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Rae K. Grad,
National Commission to Prevent Infant Mortality
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

National Commission to Prevent Infant Mortality
Switzer Building • Room 2006
330 C Street, S.W. • Washington, D.C. 20201
202-472-1364

The Honorable Lawton Chiles
U.S. Senate
Chairman

The Honorable J. Roy Rowland
U.S. House of Representatives
Vice Chairman

MEMBERS

The Honorable Otis R. Bowen, M.D.
Secretary of Health and Human Services

The Honorable Charles A. Bowsher
U.S. Comptroller General

The Honorable David F. Durenberger
U.S. Senate

Herman A. Hein, M.D.
Professor of Pediatrics
University of Iowa

William H. Hollinshead III, M.D.
Medical Director & Chief
Rhode Island Division of
Family Health

Barbara D. Matula, Director
North Carolina Division of
Medical Assistance

Julius B. Richmond, M.D.
John D. MacArthur
Professor of Health Policy
Harvard University

The Honorable Richard W. Riley
Former Governor of South Carolina

Lynda Johnson Robb
Former First Lady of Virginia

The Honorable Thomas J. Tauke
U.S. House of Representatives

The Honorable James R. Thompson
Governor of Illinois

The Honorable Diane E. Watson
California State Senate

Margaret S. Wilson, Dean
Eastern Connecticut State University

Rae K. Grad, R.N., Ph.D.
Executive Director

MEMORANDUM

TO: Witnesses from the hearing, "The Role of Government in Reducing Infant Mortality"

FROM: Mary C. Brecht, RN, MPH
Deputy Director

DATE: July 7, 1988

RE: Enclosed transcript from April 25 hearing

I thought you might be interested in receiving a copy of the transcript we had produced of the April 25 hearing of the National Commission to Prevent Infant Mortality.

Progress toward the Commisison's final report is moving along well. The release date is set for August 4, with Senator Chiles holding a Newsmakers Luncheon at the National Press Club here in Washington to annouce the report's recommendations to reduce infant mortality in the United States.

You will be receiving a copy of the Commission's final report soon after it is released. Again, we appreciate your input to this important work.

UD 026 794

NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

Fourth National Hearing

THE ROLE OF GOVERNMENT IN REDUCING INFANT MORTALITY

State of Illinois Center
Chicago, Illinois

April 25, 1988

COMMISSION MEMBERS PRESENT

THE HONORABLE LAWTON CHILES
Chairman of the Commission
United States Senator

THE HONORABLE J. ROY ROWLAND
Vice Chairman of the Commission
Member, United States House of Representatives

THE HONORABLE OTIS R. BOWEN
Secretary of Health and Human Services

THE HONORABLE CHARLES A. BOWSHER
Comptroller General of the United States

HERMAN A. HEIN, M. D.
Professor of Pediatrics
University of Iowa

WILLIAM HOLLINSHEAD III, M. D., MPH
Medical Director and
Chief, Division of Family Health
Department of Health
Commonwealth of Rhode Island

BARBARA D. MATULA
Director, Division of Medical Assistance
Department of Human Resources
State of North Carolina

JULIUS RICHMOND, M. D.
Division of Health Policy, Research and Education
Harvard University

THE HONORABLE RICHARD W. RILEY
Former Governor
State of North Carolina
Presently of Counsel with
Nelson, Mullins, Riley and Scarborough

LYNDA JOHNSON ROBB
Hunton and Williams

THE HONORABLE JAMES R. THOMPSON
Governor
State of Illinois

MARGARET S. WILSON
Executive Dean
Eastern Connecticut State University

OTHERS PRESENT

IRVING HARRIS
Harris Foundation

THE HONORABLE CHARLES A HAYES
Member, U.S. House of Representatives

National Commission to Prevent Infant Mortality
Switzer Building • Room 2006
330 C Street, S.W. • Washington, D.C. 20201
202-472-1364

NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

Fourth National Hearing

"THE ROLE OF GOVERNMENT IN REDUCING INFANT MORTALITY"

April 25, 1988
State of Illinois Center
Chicago, Illinois

Introductory Briefing

The Honorable Lawton Chiles United States Senate Commission Chairman	**The Honorable James R. Thompson** Governor State of Illinois Member of Commission

Panel I Setting a National Policy Agenda for Mothers and Infants

To make further progress in reducing infant mortality, the subject of children's health and wellbeing must become a highly visible public issue. Many government leaders have made infant mortality and maternal and child health key issues. Witnesses will describe why and how they made these issues policy priorities and will offer recommendations for setting a national public policy agenda for mothers and infants.

Witnesses:

The Honorable Otis R. Bowen
Secretary of Health and Human Services, Washington, D.C.

The Honorable Richard Durbin
U.S. House of Representatives, Springfield, Illinois

The Honorable Richard Riley
Former Governor of South Carolina

The Honorable Robert Scott
Virginia State Senate, Newport News, Virginia

Julian T. Bolton
Commissioner, Shelby County, Tennessee

Panel II Federal, State and Local Leadership in Reducing Infant Mortality - Intergovernmental Concerns and Solutions

Certain themes recur in policy debates on reducing infant mortality and promoting the health of mothers and infants. One major theme continually heard is the need for better coordination and integration of federal/state/local programs which target the childbearing population. These programs include Medicaid, the Special Supplemental Food Program for Women, Infants, and Children (WIC), the Maternal and Child Health Block Grant, Community Health Centers, Migrant Health Centers, and health educational programs. Witnesses who work in these areas on the federal, state, and local level and others will discuss issues concerning intergovernmental and interagency relationships between these programs and suggest possible solutions.

Witnesses:

The Honorable John Bode
Assistant Secretary of Agriculture, Washington,D.C.

The Honorable William Roper
Administrator, Health Care Financing Administration
Washington, D.C.

The Honorable David Sundwall
Administrator, Health Resources and Services Administration
Washington, D.C.

Jeannie I. Rosoff
President, Alan Guttmacher Institute. New York, New York

Barbara Matula
Director, North Carolina Division of Medical Assistance

Loren Bell
Director, WIC Program. Olympia, Washington

William Hollinshead, MD
Medical Director, Rhode Island Division of Family Health

Caroline Gaston
Principal, New Futures School. Albuquerque, New Mexico

E. Frank Ellis, Jr.
President, Swope Parkway Clinic. Kansas City, Missouri

Sister Jeanne Meurer, CNM, MS
Assistant Professor, University of South Florida. Tampa, Florida

Diana Robinson
Family Advocate, Center for Successful Child Development
Chicago, Illinois

OPENING REMARKS

The Honorable Lawton Chiles 1

The Honorable James R. Thompson 2

PANEL I: SETTING A NATIONAL POLICY AGENDA FOR MOTHERS AND INFANTS

The Honorable Otis R. Bowen, Secretary of Health and Human Services 3

The Honorable Richard Durbin, Member, United States House of Representatives 6

The Honorable Richard Riley, former Governor of South Carolina 9

The Honorable Robert Scott, Senator in the Commonwealth of Virginia 11

Julian T. Bolton, Commissioner, Shelby County, Tennessee 13

PANEL II: FEDERAL, STATE AND LOCAL LEADERSHIP IN REDUCING INFANT MORTALITY--INTERGOVERNMENTAL CONCERNS AND SOLUTIONS

The Honorable John Bode, Assistant Secretary, United States Department of Agriculture 24

The Honorable William L. Roper, Administrator, Health Care Financing Administration 25

The Honorable David Sundwall, Administrator, Health Resources and Services Administration; accompanied by Dr. Vincent Hutchins, Deputy Director, Bureau of Maternal and Child Health and Resources Development 28

Jeannie I. Rosoff, President, Alan Guttmacher Institute, New York 31

Barbara Matula, Director, North Carolina Division of Medical Assistance 34

Loren Bell, Director, WIC Program Olympia, Washington 39

Caroline Gaston, Principal, New Futures School 42
Albuquerque, New Mexico

E. Frank Ellis, Jr., President, Swope
Parkway Health Center 44
Kansas City, Missouri

Sister Jeanne Meurer, Assistant Professor,
University of South Florida 47
Tampa, Florida

Diana Robinson, Family Advocate,
Center for Successful Child Development 50
Chicago, Illinois

PROCEEDINGS

OPENING REMARKS

SENATOR CHILES: Good afternoon. I want to begin this afternoon by offering my thanks to the Governor and his fine staff for the hospitality that has been extended to our Commission members. We are certainly grateful to be here among our many distinguished witnesses and guests.

Congress created the National Commission to Prevent Infant Mortality because we believe that the health of the Nation starts with the healthy birth of a child. This hearing reaffirms that belief.

Our aim today is to explore what can be done to improve the health of a child from the very beginning of life. This is not our first hearing. Already we have looked into what the private sector can do, held a hearing at the United Nations Building in New York and talked about what other countries are doing--many of whom are doing a better job that we are, and we have been to Los Angeles to see what the media can contribute to the public's overall awareness of children's issues.

Now we want to examine what Government can do. The fact that the Commission exists at all provides some evidence. Our experience so far tells us that people are willing to respond, many are willing to contribute their time and expertise, and others have been receptive to the need to dramatize the problem of infant mortality.

Our role on the Commission up to this point has been to help frame the problem and to mobilize support in pursuit of a solution. We think Government can do more than that.

It is a hard truth of our time that money is limited by deficits, both at home and abroad. It is limited further by many competing demands. So it seems that we have an obligation to help financially, wherever we can. But since our dollars are limited, we have to also avoid duplication and confusion.

We are going to hear today from a quality cross section of people in state, local and the Federal Government. I hope the discussion will focus on practical approaches. We need to find ways to integrate maternal and child health programs at all levels of Government so that those in need are not overlooked.

We are going to begin with opening statements from our first series of witnesses, followed by a discussion, and then the presentation of our second panel.

I want to encourage all of you, Commissioners and witnesses alike, to speak your mind and to ask questions. If we are lucky today, we may touch on the vitality and imagination among our guests that can lead us to still more ideas.

I want to begin today by calling on Governor Jim Thompson to lead off. Again, Governor, we offer our sincere thanks for the kindness and concern that you have shown to us on this trip. Governor Thompson.

GOVERNOR THOMPSON: Mr. Chairman, thank you. It is with a great deal of pride for this Governor that the National Commission to Prevent Infant Mortality comes to my home state for this hearing, and that we were able today to take our first field trip as a Commission to the Beethoven Project at the Robert Taylor Homes.

We welcome you to Illinois and tell you that we have much to be proud of in this state. But there is no pride at all in our infant mortality rate.

Each year proportionately more children in Illinois die before reaching their first birthday than in any other northern industrial state.

We have made some pretty dramatic progress through the years, down from 25 deaths per 1,000 live births in 1960 to 16 deaths per thousand in 1977 when I became Governor, to 11.5 deaths in 1987, our last year.

Sixteen per 1,000 births is what I faced when I became the Governor of this state. Since that time, that has been a startling and unacceptable statistic in my mind.

So even with limited resources, in partnership with the Federal Government, local communities and the private sector in Illinois, step by step we have mobilized all that we have available, to increase the availability of prenatal care, to target medical care for high-risk mothers and babies, to monitor for preventable genetic diseases, beginning the "Parents Too Soon" program which is now a national model, the "Families With A Future" program, and to replace declining Federal funds with state general revenue fund tax dollars.

I would like to have the Commission recall, if it would, these words of Judy Carter from the "Ounce Of Prevention Fund" which we heard on January 11, 1988 in our hearing in Atlanta. Now that we've had our field trip this morning, I think they become more meaningful.

The Center for Successful Child Development, the Beethoven Project, puts the problem of infant mortality and the potential solutions for preventing it into an appropriate perspective.

The problem is not just a medical one and its solution is not merely a medical solution. It is a community-wide problem with many parts for too many communities in our country. To prevent infant mortality, we have to change some things as well. We have to discourage teenagers from becoming parents. We have to provide the basic nutritional needs of mothers and infants. We have to remove the barriers that discourage doctors from treating poor women. We have to view our public health system as more than counting the number of nurses in an area or the number of hours a doctor is in a public health clinic. We have to link pregnant women with a support system which values and protects the life they carry, a system that actively encourages the participation of people in it.

Beethoven has a long way to go. All of our programs have a long way to go. But I think we saw something this morning, Mr. Chairman, that gives us hope that we are on the right track. Thank you very much.

SENATOR CHILES: Thank you very much, Governor. We will start with our first panel. Our first witness is the Honorable Otis R. Bowen, the Secretary of Health and Human Services, who also sits as a member of our Commission. Secretary Bowen, we are delighted to have you with us today.

PANEL I: SETTING A NATIONAL POLICY AGENDA FOR MOTHERS AND INFANTS

SECRETARY BOWEN: Thank you very much, Senator Chiles and Governor Thompson, fellow members of the panel, and ladies and gentlemen.

I welcome the opportunity to discuss with you what the Federal Government is doing to address the problem of infant mortality.

It is always nice to begin with good news. I am happy to report that our latest provisional data, reflecting the period from January to October 1987, show that the steady decline in the rate of infant mortality has resumed.

As you know, that decline, which began some 30 years ago, showed signs of slowing down in 1985. Apparently the efforts of all of us paid off, however, because two years later the downward trend was clearly re-established.

There are still pockets of resistance, so to speak. The rate of Black infant mortality is still twice that of whites and remains high in places like Indianapolis and Washington, D. C.

In addition, there does not appear to be any change in the incidence of low birthweight. There is even a slight increase in the percentage of very low birthweight infants, and there has been no improvement in the percentages of women receiving no prenatal care or in those entering care in the first trimester.

Despite some good news, our work is still cut out for us. On the Federal level, where the responsibility resides in the Department of Health and Human Services, we are waging the campaign on a number of different fronts.

We are conducting or sponsoring basic research into the causes of low birthweight and prematurity. We are applying research with programs to reduce cigarette smoking, alcohol and drug use, and poor nutrition during pregnancy, and to prevent teenage pregnancy.

We are conducting epidemiological surveillance, tracking the prevalence of poor outcomes nationwide in the states and in local communities, and monitoring progress in improving these outcomes.

And, we are attempting to ensure access to services for the unserved and the underserved by providing both medical care coverage and prenatal coverage to the poor.

A real obstacle to providing greater access to prenatal care is the specter of malpractice liability, which is restricting both the number and the availability of obstetricians.

Last August, a special Department Commission issued a report on the general problem of medical liability. That was followed by proposed model legislation for the states to adopt.

We will soon support a symposium to be held by the Institute of Medicine on the effects of liability on the delivery of maternal and child health care.

Almost all of our infant mortality efforts are concentrated in two components of the Department of Health and Human Services. They are the National Institute of Child Health and Human Development, and the Bureau of Maternal and Child Health and Resources Development.

Within this framework, we formed, in 1984, a Low Birthweight Prevention Work Group which serves as the focus and coordinator of our efforts to develop and organize a sustained and responsive approach to the problem by identifying policy issues and implementing special initiatives.

We work closely with states, local communities, the health professions and the private sector to target and reach areas of populations with the most pressing maternal and infant health needs. The chief vehicle of our cooperation is the Maternal and

Child Health Block Grant Program, which provides formula-based allocations to states to support a broad range of services including preventive primary care and rehabilitative support for mothers and children.

With a great deal of state flexibility built into the program, the primary emphasis nationwide is the integration of Federal, state, local and private efforts.

This kind of collaboration encourages communication, keeping Federal priorities targeted in the needed areas, and enables talents and resources to be used efficiently.

Even though the effort is comprehensive, there is always room for improvement. We are, indeed, open to suggestions. Directing the Federal effort as Secretary of Health and Human Services and serving on this Commission, I am more than willing to be a catalyst in both directions.

The problem is only going to yield to the concerted force of the best in all of us. I look forward to today's discussions. Thank you, Senator.

SENATOR CHILES: Thank you, Mr. Secretary, for that statement. I would again say how delighted I am that you are serving as a member of the Commission and how helpful you and your staff have been as we have tried to go forward with this work.

Having said that, Doctor, maybe it is a thing of emphasis, but I would hate to characterize what we have received as provisional data for a period of time of January through October as being good news or that things look like they are getting better, when I see that there has been no change--in fact, it's going the other way--with regard to birth weight and even a slight increase in the percentage of low birthweight infants, no improvement in the percentage of women receiving prenatal care or in those entering care in their first trimester. Those are to me the best indicators that we have not turned this around.

We are still in terrible trouble. In this country, where we rank, below the countries of Hong Kong and Singapore and others, I think it is still a national disaster and a national disgrace.

I think that means that we do have to redouble our efforts. It is a little bit like the news I have been hearing about cocaine. There is a survey that says that maybe there has been a decrease in the number of high school seniors that are using cocaine, but at the same time there is an increase in the number of emergency room deaths from crack cocaine.

So you read the figures on one hand and you see the disastrous results on the other. If there are fewer women getting care, and if there is a worsening in low birthweight--we know that is the principal cause of our infant mortality--I just don't think we can characterize that as being very good news.

SECRETARY BOWEN: Mr. Chairman, I did not mean to imply that we had turned the corner, but I thought we ought to have just a little bit of good news to keep us encouraged.

We have a long way to go. You are totally right that we do need to place emphasis on targeting the care that is necessary to the increased number who are not receiving good care.

SENATOR CHILES: Thank you, sir. We will now hear from the Honorable Richard Durbin, a member of the United States House of Representatives from Springfield, and a person who has been a leader in trying to provide the proper medical care and proper services at all levels for women, and to take care of our infants. The Honorable Richard Durbin, Member, United States House of Representatives.

CONGRESSMAN DURBIN: Thank you very much, Senator Chiles, Governor Thompson, members of the Commission. Thank you for the invitation to be here today.

I think in follow-up to what you just said, Senator, we are all sensitive to the fact that although America is a great place in which to live, it is much safer, statistically, for an infant to be born in Singapore, Spain or Hong Kong.

If it happens to be a Black American infant, it is safer to be born in Colombia in South America or Korea than it is to be born in the United States.

The infant death rate in America is not a failure of medicine, though. It's a failure of society.

We have the medical knowledge. We know the grim statistics if we fail to act. What is lacking is our commitment.

I salute Governor Thompson, Irving Harris, Dr. Turnock and many other officials for the fine work that they have put into this Beethoven Project here in the Chicago area.

These projects are essential. But simply demonstrating a cost-effective solution to a problem may not be enough when it comes to helping poor people. In President Reagan's last State of the Union address, he said that "Several years ago we fought the War on Poverty and poverty won." People laughed on the floor of the House of Representatives.

But if you look at the cold, hard facts, many of the programs in the War on Poverty were successful, not the least of which was the Headstart Program for which we now have 25 years of statistics demonstrating proven success in keeping kids from being drop-outs, in helping those kids stay in school, not to become teenage mothers, to avoid becoming welfare and crime statistics.

Yet today, with this proven knowledge, with this body of information in front of us, how many Headstart kids are involved? One out of six.

So when we look at these issues politically, particularly at the state level, I have to harken back to some advice given to me by a Chicago politician several years ago.

He said, "As you get into this business, you will soon realize that when it comes to political issues there is always a good reason for a position you take and then there is a real reason."

The good reason that we are involved in the infant mortality debate in this country and this Commission's fine work is that we are disgraced as a nation with our infant mortality rate.

Our children are dying and we know we can save them. These arguments are compelling, but they may not be politically persuasive.

Some have suggested that we are not going to hit the standard of 9 by '90, which was set as our national goal. So let's look beyond the good reason why we should be in it and talk about some real reasons that might build a political consensus.

In the first place, we are going to bankrupt our nation if we don't come to grips with this problem. Our failure to solve this problem will cost us dearly in medical bills to the Government at all levels, uncompensated losses by hospitals, special education teachers who will be needed because of disabilities these children will suffer, more welfare recipients and more crime statistics, wasted lives of tomorrow's workers.

The irony, of course, is it is within our reach to do something about it. We can deliver comprehensive prenatal care to all of the poor pregnant women in the United States who are presently not served at about half the cost that we are presently paying for the sick infants in America for their first year.

We spend about $2.1 billion a year for those sick children. For half of that amount, we can avoid the human tragedy and the cost.

The Select Committee on Children, Youth and Families on which I serve in the House of Representatives is trying to build a bipartisan political consensus on these issues to try to make sure that we have adequate funding for the WIC program.

There is just no excuse for the fact that fewer than half of the eligible people in America are presently receiving those services.

This consensus is being built to make certain that the maternal and child health care block grants are adequate to help the states move forward with innovative approaches and to keep such things alive as the National Health Service Corps of physicians who are absolutely essential in many of our community health centers.

We are also working on legislation to require coverage for all pregnant women and infants with incomes below the Federal poverty level. 31 states have bought into that Federal offer. 19 still have not. We want to move forward on this.

I think it's also significant that we are holding firm to the proposition that we don't create or expand any health protection to any segment of America's society without an objective appraisal of who is most vulnerable.

The legislation offered by Congressman Pepper, that Senator Chiles is well aware of, for long-term health care for seniors has an important component in it providing health care and home health care for children as well.

Senator Paul Simon is one of the Senate sponsors. I think we all realize, with Senator Simon and Congressman Pepper, that it is time we take a real assessment of where our health needs are in America.

I also note the testimony this afternoon from folks from the Alan Guttmacher Institute who will talk about the possibilities of a new entitlement. I can't think of a more frightening Roman candle to set off in Washington than to start talking about new entitlements.

But I will tell you that it's worth the debate. A means-tested entitlement that may include some trade-off with state governments when it comes to responsibility for pediatric care might be something we should put forth as part of our national agenda to discuss.

We are increasing our efforts for public awareness. With the help of the Illinois Department of Public Health, I mailed 50,000 copies of this brochure in my District offering a hot-line number to those mothers who did not have insurance.

We doubled the number of calls coming in to that hot-line number in the first month.

My colleagues in Congress are joining me in this effort and I want to thank Dr. Turnock for his cooperation. I am working with Governor Thompson as well on some public issues and public information efforts to try to get this message out.

Let me close by saying that I think the most effective programs we have seen in down-state Illinois are neighborhood and community based. It has to be that way if they are going to be effective. But we are going to need the involvement of churches, business and medical institutions.

I am confident if we make that commitment as a nation, we can get the results. Thank you, Senator.

SENATOR CHILES: Thank you, sir. I thought we would call on all of our first panel and then we will have a discussion afterwards.

So we will now call on the Honorable Richard Riley, former Governor of South Carolina, a member of our Commission and a person who has been an early leader in the fight to better our numbers on infant mortality.

FORMER GOVERNOR RILEY: Thank you, Mr. Chairman and Secretary Bowen, Governor Thompson and others.

I was asked to address the issue of "how-to" in setting state priorities for getting people involved in this issue on all levels.

I have a strong feeling that to get this particular issue moved forward, we are going to have to develop leaders in this country and on the state level.

We have had some right interesting things happening on the state level, but we are going to have to develop leaders who, first of all, believe in what we are about. These must be leaders who understand the issue, who care about children, who care about the future of this country, who believe that our human resources are, indeed, the most important thing that we have, and leaders who are willing to be pro-active, even dramatic.

These must be leaders who then could carry not just the string of rhetoric forward, but certainly some movement in this country and some real effective action.

They also have to understand the conservative nature of the issue, the cost-effectiveness of it, the fact that it is indeed an investment and not a cost.

Now, in South Carolina, we have been involved in a number of issues relating to infant mortality. I will not allude to all of them. I will be happy to later on.

Just to mention them, they are a high-risk program that screens and channels all high-risk pregnant women in our state. There was a Medically-Indigent Assistance Act in 1985 which dealt broadly with the issue of indigents and, more specifically, with pregnant women, and with indigent children.

There is the EPSDT Program, the medically-needy program, which was replaced with the SOBRA option recently. We have the "Teen Companion Program", which is targeted to AFDC adolescents to help them avoid unwanted pregnancies.

We have the "Resource Mothers" program, which was started by the Robert Wood Johnson grant, continued with the SPRANS grant, and which has since been picked up now by state dollars.

We have had very good statistics in the state. Our statistics have gone down dramatically, especially for poor Black infants.

I think, in addition to leaders, we are going to have to develop a good data base. People have alluded to that also.

I feel those leaders are going to have to come forward with a national policy. I think the policy must be strong, it must be targeted to pregnant women, infants, and children, and it must say really that we must be assured that all pregnant women and infants are provided access to health care in this country, and that no pregnant woman or infant will be denied access to health care due to an inability to pay.

Categorical restrictions such as family composition, employment status and so forth should not result in denial either.

In addition to a strong statement of policy, my final point is we need to do what we can to eliminate systems barriers that discourage access to prenatal care. I'm referring to lengthy and complex eligibility procedures.

I showed this morning, and the Chairman referred to it, our AFDC application form which is 44 pages long. It's much more difficult to complete than a corporate tax return.

I think that having bureaucratic requirements of that kind, which encourage exclusion rather than inclusion of poor pregnant women and infants, is a travesty of our democracy.

There is a lack of effective coordination of needed services, such as Medicaid and WIC, a failure to manage care so that appropriate services are accessible to pregnant women and infants with special needs, such as high-risk women or adolescents.

Mr. Chairman, those are some of my ideas. Let me say it is a pleasure serving with all of you.

SENATOR CHILES: Thank you very much. Our next witness will be the Honorable Robert Scott, a Virginia State Senator. Senator Scott has served both as a Member of the House and the Senate. He led the fight in Virginia to expand the Medicaid coverage for low-income pregnant women and their infants. He has also led the formation of a task force to study infant mortality problems in Virginia. Senator Scott.

SENATOR SCOTT: Thank you, Senator Chiles, Governor Thompson, Governor Riley, Commission members, for the opportunity to testify today.

The fight against infant mortality has been an elusive fight on the state level. I have been involved in that fight for approximately ten years, beginning with a bill to remove the Commonwealth of Virginia from the list of six states that did not provide prenatal care under Medicaid to women having their first baby.

This bill was suggested to me and I discovered very quickly one of the shortcomings of being a state legislator--state legislators do not have research staffs.

Fortunately, the evidence of the cost-effectiveness of prenatal care was easy to find. So there I was, a first-time delegate, a $1 million budget amendment, no apparent constituency in support, assuming that facts, figures, logic and a little compassion would be sufficient for persuasion.

I learned. [Laughter]

For three years, the bill was defeated. Virginia was removed from that list of dubious distinction only after we received help from one Dr. Rae Grad who was, at that time, the Virginia Perinatal Association President, and Dr. Fred Wirth, a neonatologist in Norfolk, the March of Dimes, Children's Defense Fund, and a gentle push from Governor and Mrs. Robb.

In the following years, we have passed legislation which provides for the reporting of birth defects as a vital statistic, and the testing and screening of infants for several problems that require early intervention.

We also increased fees for obstetricians, established several "Resource Mothers" programs to assist low income teenagers, and created a two-year infant mortality council of Administration and lay members.

In addition, under the Secretary of Human Resources, we established a council on prevention. Bureaucrats are often publicly supportive of prevention programs, but widely sabotage the idea as soon as they merely suspect that their agency may lose staff or funds as the result.

During the discussion of the SOBRA amendment last year, we heard as much about the impact on various agency budgets as we heard support for the proposal. This year, after receiving numerous recommendations and intense lobbying, the SOBRA option was introduced as part of the Governor's budget and passed at 100 percent.

The legislature added funds for care coordination and enhanced services.

Next year's fights at the state level in Virginia will include addressing indigent health care generally, allocating state funds for WIC, coordinating our resources, and increasing early-intervention services for developmentally disabled infants.

On the state level, it's difficult to maintain political pressure because we frequently have to make multi-million-dollar adjustments in the budget and the beneficiaries of those budget amendments lack political clout.

Therefore, without firm guidance from the Federal Government, the health care of American children across the Nation will be subject to annual last-minute late-night compromises and legislative deal-making.

I therefore hope that the Commission will consider, among other things, the following: increasing the SOBRA option to 185 percent of poverty and making it mandatory at 100 percent; increasing funds for WIC--we are now reaching only half the eligible population; increasing the number of obstetricians--in many areas of Virginia access is a problem irrespective of ability to pay--with the help of medical scholarships; assistance to OB residency programs and National Health Service placements, and outreach and support services.

Significant improvements in outcomes occur when there are nurses and Resource Mothers who have the time to support, educate, counsel and visit patients during their pregnancy and after birth.

The public health clinic in my district has achieved a low birthweight rate of 4.7 percent and a rate of 3.8 percent for those who began their services in the first trimester and had at least ten prenatal visits.

Our "Resource Mothers" program has experienced a 7.5 percent low birthweight rate, and that's for low-income minority teenagers, the highest-risk group of all.

I appreciate the opportunity to be with you today and I look forward to your recommendations.

SENATOR CHILES: Governor, we did not have any idea that we were going to have the kind of interest in this hearing that we seem to be having. I understand there are 50 or 60 people outside the room due to lack of seating capacity. We will take a short break now to add more chairs to better accommodate those here today. [5 minute break]

SENATOR CHILES: We will now call on the Honorable Julian Bolton, who is a member of the Board of Commissioners of Shelby County, Tennessee representing an inner city district of Memphis. We are delighted to have you here, Commissioner.

COMMISSIONER BOLTON: Thank you, Senator Chiles, our host, Governor Thompson, members of the Commission, and guests.

I'm very pleased to be here to have input on national policy relating to this very important issue concerning the future of children in America.

I do feel particularly qualified to speak about what we are doing in Shelby County because I do represent an area where the infant mortality rate is the highest in the county.

As well, I had a very close experience with my second child being born close to death because of low birthweight. We had this frightening experience in 1981 when our child was born at 26 weeks gestation and at 2.2 pounds. When the child was born alive, the neonatologist did not expect him to live and informed us.

We are very happy and blessed to be able to say that our child is living and thriving as a seven-year-old with the only drawback being a mild-to-moderate hearing loss. But this gave me an opportunity to take a close look at the health care delivery system.

In reflecting, I wondered. If I did not have the health care coverage to pay the $125,000 that it cost for my child to be cared for, would he be alive?

It caused me to reflect further that if my wife had not been a nursing professor and had not actually instructed most of the nurses who cared for our child, creating a close bond, would our child still be alive?

Further, if we did not have knowledge and access to high technology and high-quality health care, would our child be alive?

The truth of the matter is that many people in America today do not have access to that high technology and high-quality health care that is necessary for the survival of high-risk youth.

In Shelby County, we have a serious problem with low birthweight infant mortality. In 1984, the figures were about 14 out of 1,000 live births. That is, 8 for white babies, 18.5 for Black children.

But we are slipping because in 1987, we had an infant mortality rate of 23 for Black youths, 8 for white youth, with 15.8 infant deaths overall out of 1,000 live births. So we have been slipping negatively over the past year.

We know a key factors, teenage births. A disproportionate number of Black teenagers especially are getting pregnant early in life. They have a second pregnancy within a year.

We have many special projects in Shelby County which I have described in my prepared remarks, but what I want to discuss with you today is a very interesting and novel and holistic approach that we are initiating in Shelby County, focusing on children.

It is entitled "Free the Children." The focus is to eliminate the cancer in our midst which is a culture of poverty. It exists in Shelby County. It exists throughout America.

We are hoping to develop a model program in Shelby County which will enable local governments in partnership with industry and other governments to use the tools, such as WIC, such as the health departments, to focus on this cancer, which is a culture of poverty, and create a permanent solution for at least some of those who have lived in poverty generation after generation after generation.

In Shelby County, the County Commission has created a fund as a first step in delivering the Free the Children program. It is a $200 million fund for use over the next five years to implement this program in Shelby County.

It focuses on education. $120 to $125 million over five years will be used to build new schools, but there is also some $30 million additional dollars available for housing and several million dollars available for the administration of the program.

At first, we had to develop a commitment and a partnership between government, industry--the business community that is--and the communities at large.

We started with a commitment because we found that, in our community, although we were bringing industry to Memphis at a very high success rate--International Paper and other expansions, of course you all know about Federal Express--the jobs and the benefits of this new industry were escaping many of our families who are living in poverty.

Out of those families came the negative symptoms. Out of those families came the high infant mortality rates, the high crime rates, and the other negative symptoms associated with the culture of poverty.

We started with a commitment to bring industry, the community and government together. In Shelby County, the leadership of Mayor William Morris led the charge.

After establishing a permanent source of funding starting with the $200 million, which is funded by a wheel tax, we are now moving out to get further commitment from industry and from other aspects of government, as well.

Before we implemented the program county-wide, we had a one-year pilot project in four census tracts in the most depressed area of our community. There are about 25,000 people who virtually all live in poverty in that community.

We will be servicing and working with and case managing as many of the families in poverty as we can in that area, but we are selecting 125 families for close tracking and case management so that we can shake down and test out the theories of our cultural poverty program.

The program is described in full in the prepared remarks that I have as well as in a booklet published by Shelby County government called The Cancer in Our Midst: Memphis and Shelby County's Culture of Poverty, which will be available I assume through the Commission.

The point I wanted to make today, in addition to introducing this holistic approach to this body which deals with the root cause of the symptom of infant mortality, is that every community needs to develop its own unique program because all communities are quite different.

Memphis is different than a Rhode Island community, for instance, or a Washington, D.C. community. But it has to start with a commitment not to deal with simply the symptoms of poverty, but the root causes.

We certainly don't expect to bring all 200,000 of the people we have identified in poverty out in 5, 10, 15 or 20 years. But if we can bring 5,000 of these families out of poverty a year who have been in poverty generation after generation, we feel that we will have created something unique and new for America.

We hope that it works. We are looking for the input from many of you cross the country as you examine closely the results of the "Culture of Poverty" program.

In closing, I simply ask that you take a look at our pilot program as we implement it over the next year. We will take many indicators from the case-management aspect of the pilot program dealing with 125 families who have, generation after generation, been in poverty.

We are going to take the lead from what has been successful with them.

Secondly, we are focusing on children because we feel that many of the adults or parents, although they could use the help that local government and the program can provide, we need to save the children so that they won't be victim to the same kinds of poverty symptoms and problems that their parents and perhaps their grandparents were subjected to.

So we are focusing on the children, and infant mortality certainly is an important part relating to a child's life and a child's ability to prosper in America.

Please take a look at the "Culture of Poverty" program. Please track our results. We want to share them with the rest of the country if the program is successful.

We certainly want your input and your expertise from across the country on those aspects that are not successful.

Thank you very much.

SENATOR CHILES: Thank you. Let's take 15 minutes or so and get into a little discussion on Panel One if we can. [Break] Commissioner, you described your revenue set up at $200 million. I didn't quite understand that.

How were you able to put together the public support? How did that happen?

COMMISSIONER BOLTON: We convened 100 agencies working with the poor and industries that have been prosperous and have been successful in Memphis in what is called a culture of poverty think tank.

We analyzed the root causes of poverty in the community. We felt that the expertise of the businessmen and their staffs that had made them successful in business could help us solve poor people's problems. We wanted that expertise. We wanted that level of intelligence, and that discipline and commitment.

We brought them together in a think tank that worked for a year on a voluntary basis to analyze our community. They came up with some recommended solutions, but we had to fund them.

So we went to them again to talk about how could we fund this. The solution they came up with for the funding was to establish a wheel tax, $25 per car, to create a permanent source of funding for dealing with the problems of poor people.

Using the revenue from that wheel tax, we were able to authorize and fund a $200 million bond issue, which is county government's initial contribution to the effort.

We are hoping that city government, state government and the Federal Government, as well as the foundations, will also chip in to help us create a national model for eliminating the culture of poverty in America.

SENATOR CHILES: Were you able to pass that tax just with the Commission or did you have to go to the state legislature, or what?

COMMISSIONER BOLTON: We wanted a tax that we had the authority to pass. I might add that the tax passed with the unanimous support of the Shelby County Board of Commissioners.

SENATOR CHILES: How have the people accepted that?

COMMISSIONER BOLTON: The people had a little difficulty accepting it. There's no doubt about it. [Laughter] But it takes this kind of courage to address problems that we have been experiencing.

Everyone knows that there is something going wrong in Memphis because we have two economies, one prospering and one floundering. So we came up with the solution.

The elected officials worked in their communities to try to give the message that this is important to the future of Memphis and Shelby County.

We had difficulty. We had some backlash from it, but we have moved on from the issue of the wheel tax now and we are working on other things in the community.

It was a temporary backlash, a serious backlash, but the fact that the County Commission worked together and voted unanimously helped strengthen the position that the elected officials had to take in dealing with their constituencies.

SENATOR CHILES: Governor?

GOVERNOR THOMPSON: Mr. Chairman, I wonder if we might have Congressman Durbin describe the program that he and I and others in state government are working on together, he in his district and the rest of us state-wide, in building public awareness of such a thing as infant mortality.

There are a great many people in Illinois to whom that doesn't mean anything because they have no contact with it. Those of us who care about it are sort of preaching in the abstract wilderness.

I wonder if he might describe for the Commission and our guests today those steps that are being taken, particularly with the Illinois State Association of Broadcasters, and others, to build this public awareness.

CONGRESSMAN DURBIN: Thank you, Governor. We have found, in my home community in the capitol city of Springfield, we have a wealth of medical talent.

There are two major hospitals and a teaching university at Southern Illinois School of Medicine.

But we also found, about a year ago, that of our 22 obstetricians in the capitol city of Springfield, 17 refused to treat Medicaid mothers or poor pregnant women.

I worked with Governor Thompson and representatives of the Illinois Department of Public Health, and we brought together a Saturday morning meeting of all of the people whom I considered to be somewhat involved in it, including representatives of the medical society and the like.

As a result of that meeting and several conferences afterwards, we debated the possibility of moving toward a clinic which would have special treatment for poor mothers.

That was rejected, I might add, by the doctors in the community. They said that they would prefer treating these mothers in their own offices. They thought it would be a waste of their time and resources to set up a clinic.

We are trying to use St. John's Hospital in Springfield, now, as a clearinghouse, through a group known as the Care Center, to refer each and every poor pregnant mother to a different obstetrician.

At this point, it's working well. The doctors who previously have not treated Medicaid mothers are now accepting them. The hospital helped a great deal by informing them that, as part of its staff, they were expected to participate. This has come a long way.

SENATOR CHILES: Gave them an offer they couldn't refuse.

CONGRESSMAN DURBIN: Yes, they did. [Laughter] What the Governor has pointed to, I think, is the other part of this. It is not just a question of access, as I'm sure this Commission knows, but it's a question of the knowledge of the mother of the absolute necessity to get in to the doctor early on.

I sent out this brochure and I will tell you we are somewhat limited in the print media, particularly something coming through the mail box, that is going to be read by some but perhaps not all of the folks who need to know the information the most.

I have worked with Governor Thompson and his Administration, and I think we have reached an agreement with the Illinois Association of Broadcasters that they are going to help us embark on a campaign to make this message more specific and state-wide.

We have also had other groups, business groups, in the state express an interest in the last several weeks. We will be making some announcements on that front.

But I think this is essential, that the level of public awareness reach the point where that mother knows there is a need early on. Then, once perceiving that need, she needs to know where to turn for help.

If we can find that mechanism, create it in the State of Illinois, I think we will go a long way towards solving our problem.

SENATOR CHILES: Thank you. Yes?

DR. HEIN: Thank you, Mr. Chairman. I have a question of Secretary Bowen. Mr. Secretary, you indicated the Department of Health and Human Services is waging your campaign on a number of fronts and referred to some educational activities to reduce cigarette smoking, alcohol and drug consumption and improve nutrition during pregnancy, and to prevent teenage pregnancy.

Has any of this campaign been waged in the public schools directly and, if so, how?

SECRETARY BOWEN: Not to my knowledge is our Department waging it directly in public schools. We are furnishing the results of research and we are furnishing information to them.

The Department of Education has their own programs for this type of effort. Dr. Sundwall may have further information on it.

DR. SUNDWALL: I believe that if we were to dissect where our monies go, we would find that a fair amount of that does translate into school education, for example through our MCH block grant and even some of the SPRANS grant.

Some of that, I believe, does end up in direct educational activities.

SECRETARY BOWEN: That is through the states.

DR. SUNDWALL: Yes, it's money that we provide, but the states administer it.

DR. HEIN: Are you applying any leadership to this data specifically or is this just an optional thing at the state level?

DR. SUNDWALL: As far as funding health education programs in schools, no, we don't do that through the Public Health Service.

DR. HUTCHINS: We have some $526 million this year in the Maternal and Child Health block grant, of which $444 million, the vast majority, goes directly to the states. They have great flexibility on how they use this.

DR. SUNDWALL: One more probable source of funding of school health education program is through Title XVII. That's for health promotion and disease prevention activities.

I'm certain that the materials that are generated by Dr. McGinnis in that organization are utilized in public education.

SENATOR CHILES: We certainly applaud the Commissioner of Shelby County and others for all that they have done. One question out of curiosity, and the other one very serious. Has there been an election since the wheel tax was passed? And how did the Commissioners fare? [Laughter]

COMMISSIONER BOLTON: There has not been an election since the wheel tax was passed. Quite honestly, I don't feel that the wheel tax will really be an issue in the election.

I'm the newest member of the Board of Commissioners. I'm now on my seventh year on the Board. Most of the Commissioners, quite frankly, have been there 15, 20 years.

There have been some much more controversial issues--such as the anew regional medical center, a $60 million new public issues--that have come before the community than the wheel tax.

They survived it. So I really don't think it will be an issue in the election. As a matter of fact, the attention that Memphis and Shelby County is getting because of our efforts has begun to excite the citizens in the community about our program.

They are beginning to think now that, "Hey, we really do have something."

As well, $120 to $125 million of those dollars are extra dollars to build schools in a deteriorating inner city as well as in the outlying counties where they need schools.

The tax was a little tough to swallow, but we are beginning to apply the salve now with the benefits of that tax. I think that the community really will be pleased with what we do in our community with those dollars.

SENATOR CHILES: You could not have done it had it not been for the state having given you the authority to tax. Is that not right?

COMMISSIONER BOLTON: That's correct. We have had the authority to implement the wheel tax since we have had charter government, which was initiated in 1986. We knew we had that taxing authority.

That's the only taxing authority other than a property tax that the county has. We did not want to add to the property tax because we felt that that would really hurt the senior citizens.

But people who have three and four cars can afford to pay an extra $100 for four cars, $25 a car, but a lot of people who have property may not be able to afford the additional property tax levy that would have been the result of the "Culture of Poverty" program.

SENATOR CHILES: Congratulations.

COMMISSIONER BOLTON: Thank you.

SENATOR CHILES: Commissioner Wilson?

COMMISSIONER WILSON: The exchange around the issue of health services in schools reminded me that that's one of the issues that this hearing is all about.

How often does Health and Human Services talk with the Office of Education? How often do state health departments plan with state boards of education around the delivery of health services through the physical plant of the schools?

The pregnancy which causes the drop-out causes the lack of education which causes the lack of a worker in another 20 years.

Can we have some talk around that issue? How often do you talk with the Office of Education in terms of what they are doing with their money and what you are doing with your money?

For any of you on the state level, can we talk about that in terms of state departments and state boards of education, and their working together to deliver the programs to the kids in the schools?

SECRETARY BOWEN: We have frequent meetings, mainly through the Domestic Policy Council of which both HHS and the Department of Education are members. These items are discussed quite regularly there.

One of the other efforts that we have in our Department is to work closely with the states, and local and private organizations. We try hard to provide leadership in calling attention to the various problems, and then formulating and fostering the solutions.

We try to constantly expand the knowledge through basic research as to the causes, specially in the low birthweight and prematurity. Then we have applied research and demonstration of intervention through support programs to reduce the use of tobacco, alcohol and drugs, and the situation of poor diet.

We do epidemiological surveillance and tracking prevalence of poor outcomes and successful outcomes. We will be watching Shelby County closely to see the effect of that program.

We like to give the states as much flexibility as we can so we have essentially 50 laboratories out there. We can determine, then, what works and doesn't work and pass that information around to all of the states.

I don't know whether or not that answers your question. We have a lot of inter-departmental conversation on that.

SENATOR CHILES: Congressman Durbin.

CONGRESSMAN DURBIN: If I might respond to that, my district includes Decatur, Illinois which unfortunately has the distinction of ranking second or third in our state in terms of infant mortality.

Last year in Decatur, Illinois we had one 12-year-old mother, one 13-year-old mother, and we had three 19-year-old mothers who each had six children. The need for this information to get down to grassroots level and even to lower-level grades is there.

I have spoken to our superintendent of schools, Ted Sanders, here in Illinois. They are taking a look at some of the curriculum recommendations that they will be making to our schools to at least start a general education so that children come to appreciate at least the need for early nurturing of a child.

It's hard to believe that we will have to start at that level, but I might tell you that I recently went to a fifth grade class in Rochester, Illinois and the wall was covered with posters about "Just Say No To Drugs".

That's a rural community which you would never guess would be touched by that problem, but they are very sensitive to it. Kids are worried about drugs today where I might have been worried about bicycles and baseball gloves.

I think it's part of the reality, and we have to accept the political reality that this is not always going to be an easy thing to implement.

SENATOR CHILES: Senator Scott?

SENATOR SCOTT: Senator, just very briefly I wanted to mention the Prevention Council that we established in Virginia.

The problem that Commissioner Wilson spoke to, that the health department and education department aren't speaking to each other, occurs frequently in drug programs which include health, social services and these matters.

In coordinating those activities, it is helpful to have one council that can discuss all of the ramifications of that and possibly come up with a solution.

Many of the budgets that may save money aren't the same budgets that have to spend money, and some of them aren't even the same secretariats. So the Prevention Council is working right now to try to alleviate some of those problems.

SENATOR CHILES: Thank you. We will move on now to our next panel. I want to invite our audience to take a brief break and then we will move on.

I will ask our next panel to try to hold their statements down to, hopefully, around four minutes. We have eleven members and we want to have a chance to have a little discussion.

I want to assure you that all of our Commission members have read your statements. I'm going to give them a quiz on them afterwards. [Laughter]

[A brief recess was taken.]

PANEL II: FEDERAL, STATE AND LOCAL LEADERSHIP IN REDUCING INFANT MORTALITY--INTERGOVERNMENTAL CONCERNS AND SOLUTIONS

SENATOR CHILES: We will resume. The first person to speak to us on Panel Two is the Honorable John Bode, Assistant Secretary for the Department of Agriculture in Washington, D. C.

ASSISTANT SECRETARY BODE: On behalf of the U. S. Department of Agriculture, with respect to its role in reducing infant mortality, in particular I should note that the Department of Agriculture has some 13 Federal food assistance programs, the largest among them the food stamp program.

Of relevance today is the Special Supplemental Food Program for Women, Infants and Children, commonly known as the WIC program, and the much smaller but similar in operation, Commodity Supplemental Food Program.

The most important difference between these is that the Commodity Supplemental Food Program provides packages of commodity foods.

Of course, poor prenatal nutrition is one of the high-risk factors affecting birth weight. The WIC program and the Commodity Supplemental Food Program provide low-income participants with supplemental foods and nutrition education which can positively affect maternal nutritional status and, in turn, positively affect birth weights.

The supplemental food packages provided by WIC and Commodity Supplemental Food Program are rich in the nutrients which are often found to be lacking in the diets of the target population. Nutrition education provided at WIC clinics teaches women about the importance of a good diet during pregnancy and often includes counseling on other risk factors, such as drinking alcohol and smoking, which adversely affect birth outcomes.

Standing alone of course, the WIC program cannot substitute for adequate prenatal care. However, WIC program efforts to introduce participants into a health care network through referral to and coordination with health care providers augment the availability of prenatal care.

A priority system has been developed in the WIC program to ensure that the highest risk eligibles are served first by the program. Due to the link between prenatal nutrition and low birthweight, WIC includes high-risk pregnant women in priority one.

There is a great deal of state flexibility in administration of the WIC program. My testimony includes quite a number of special initiatives to prevent and reduce infant mortality that WIC or local agencies organize or participate in. I will simply leave that for people to review at their leisure.

I should also note, though, the issue of funding for the WIC program which has already been mentioned a couple of times today. WIC is already a well-targeted program because of the priority system I referred to and serves a large proportion of the eligible low-income pregnant women and infants.

In fact, WIC already receives enough funding to serve all of the pregnant women and infants with a medically-based nutritional risk. An increase in WIC funding would probably go to serving children and others in the lower-priority groups.

Contrary to some views, WIC is no longer a small program. Since 1980, its funding has increased over 130 percent. WIC is well-targeted and widely available to the population where it seems most effective.

I also want to note that for fiscal year 1989 the WIC program and the Commodity Supplemental Food Program are proposed by the Department of Agriculture to be combined in a single appropriation.

Our goal is to allow states to better focus the funds to meet the needs of the highest-priority groups. For example, in 1987 the relatively small Commodity Supplemental Food Program converted 4,074 caseload slots for women, infants and children to elderly people because, through that program, the assertion that was made was that women, infants and children could not be served.

A combined appropriation would allow these resources to provide services to the target group of women, infants and children as well as take advantage, in cases where it's appropriate, of the relatively lower cost of the food package through the Commodity Supplemental Food Program.

So that is an opportunity that exists to make better use of the resources available. We hope that the Commission will take that into consideration.

I appreciate the opportunity to be here, Senator.

SENATOR CHILES: Thank you very much. Our next witness will be the Honorable William L. Roper, the administrator of the Health Care Financing Administration. Dr. Roper.

DR. ROPER: Thank you. Senator, Governor, Mr. Secretary, members of the Commission, I'm delighted to be here and especially glad as a pediatrician to be here.

Before coming to the Federal Government, I was Director of Public

Health for my home town, Birmingham, Alabama, and Jefferson County surrounding it.

I would just say, in introduction, that it is possible to integrate many different kinds of programs into a single program targeted at women and children.

We ran a network of eight neighborhood health centers with maternity programs, a well-child program, a WIC program, and family planning. These were all linked to the county public hospital and the university hospital.

We had, I think the first in the Nation, a computer system to link the records for our clinics to the hospital delivery rooms. It is possible, with difficulty, to link these various programs together.

I would just say, in passing to Dean Wilson's question, that it was easier for us in the health part of our department to communicate with the education department when it was a single department. We are now separate.

I am here talking about the Medicaid program, which is a part of my agency. In the Health Care Financing Administration, we administer Medicare and Medicaid.

Medicaid, as you know, is a joint Federal/state program with state direction under general Federal oversight. We pay for health care for 11 million children.

It's the primary source of health care for the most vulnerable of these children, the poor and the disabled.

Medicaid is directly addressing the problem of infant mortality and the high incidence of low birthweight babies at its sources by providing access to quality prenatal and maternal health care services for high-risk pregnancies.

Since Medicaid is a program operated by the states, the real story is how the states are, with flexibility, meeting the challenge of caring for low-income mothers and infants.

In the Federal program, in the Health Care Financing Administration, we are committed to working with states to help them meet these challenges.

Under legislation passed in 1986, states can now provide Medicaid coverage for pregnant women and for certain children not eligible for AFDC because their incomes exceed state standards.

20 states now cover pregnant women up to 100 percent of the Federal poverty level. Another 23 are considering this optional

coverage. That total of 43 states would provide coverage for women with incomes of $11,650 for a family of four.

One of the states not yet covering these women but about to, I believe, is my home state of Alabama. I had the pleasure of going down in January to assist Governor Hunt, as did Rae, to urge the people of Alabama to get behind this program to fully protect the women below the poverty line.

The National Governors' Association reports that 34 Medicaid programs have state approvals for this 100 percent of poverty option. A further 7 states may well select, this year, the new option under the 1987 Omnibus Budget Reconciliation Act to allow states to cover women up to 185 percent of poverty.

They also have expanded coverage for children in poverty. Some 11 states cover children through age 2 in families with incomes up to the poverty line.

As a result of all these changes, an additional 650,000 low-income women and children will be covered at the end of fiscal year 1989.

We are providing practical ways to meet a clearly documented need for improvements in access to quality prenatal care. In the Health Care Financing Administration, we have established a Maternal and Child Health Assistance Group to try to draw officials together from Medicaid, maternal and child health agencies, WIC programs, and state and local health departments to meet this challenge together.

Another recent change is to allow so-called presumptive eligibility, that is, streamlined eligibility for Medicaid. 12 states have adopted this option.

They place eligibility workers at major hospitals, clinics and large providers to make becoming eligible for Medicaid easier.

Another important part of the Medicaid program serving young children is known as EPSDT, the Early and Periodic Screening, Diagnosis and Treatment program. That's a mandatory program providing health screening and treatment to Medicaid recipients below age 21.

This program is augmented in 24 states by pre-pregnancy care and counseling to teenagers, prenatal services for pregnant teens.

Just last month, we mailed a new Medicaid manual instruction on the EPSDT program to the states to give the more clear direction on implementation of this program. The Academy of Pediatrics was particularly helpful to us in writing this new manual instruction. Under this program, last year 3 million children were cared for.

Let me just add, finally, this point of gathering together officials from the health care financing world and the public health world is something that's important to me personally.

Next month I'll be meeting with the Association of State and Territorial Health Officials, the state health officers and the state Medicaid directors. A major focus of each of these groups is how better they can work together.

Medicaid works in preventing infant mortality. A recent study in, again my home state, Alabama showed a Medicaid infant mortality rate--that is, an infant mortality rate to women who were on the Medicaid program--of 9 per 1,000 live births compared to 12-1/2 for the state as a whole.

Thank you very much.

SENATOR CHILES: Thank you, sir. We will now hear from Dr. David Sundwall, who is the Administrator of the Health Resources and Services Administration.

DR. SUNDWALL: Thank you, Chairman.

DR. SUNDWALL: I'm delighted to be here today. I'm here in the capacity of representing Dr. Robert Windom, who is the Assistant Secretary of Health. He has asked me to represent the Public Health Service. With me is Dr. Vince Hutchins, who is the Deputy Director of the Bureau of Maternal and Child Health and Resources Development. If you have any hard questions, I'm going to have him answer them.

Dr. Hutchins has been in this business a very long time. As we discussed this morning, I only wish I had a half an hour to an hour to tell you all the good things that are going on in the Public Health Service related to reducing infant mortality. But I promised I would be good and limit it to just a few brief remarks. We will submit more testimony for the record.

Let me just summarize by suggesting that the Public Health Service sees itself as having a national leadership role not just to reduce infant mortality. We see our role as encompassing more than that.

The prevention of low birthweight is a very important goal of ours now. Reduction of accidents and infectious disease in infants, and the promotion of optimal growth and development for all newborns are equally important goals.

We approach these laudable goals in three main areas: number one, through research and data collection; two, through actually delivering health care through a network of community health centers and migrant health centers to especially needy populations; and three, by encouraging cooperation and collaboration between other public and private sector entities which are also interested in reducing infant mortality.

First of all for research. The preponderance of activity there is, as Dr. Bowen has said, the National Institutes of Health in its National Institute of Child Health and Human Development.

We are working to expand our knowledge of what really causes or is associated with infant mortality, but also to develop new and better ways of obtaining data. Our data-collection efforts are primarily in the National Center for Health Statistics, which is part of CDC.

As you know, among the Commission members there has been quite a bit of concern expressed about whether we are using comparable data.

Are we comparing states fairly? Are we comparing ourself with other nations fairly? Dr. Bowen asked me to have the National Center for Health Statistics prepare for the Commission members a document which will give you our best and most up-to-date information on statistics and how comparisons are made, and if we need to improve in this area.

I will have that distributed to all of you before you leave today. Some examples of what we are doing in research I will provide are the following.

A study is currently underway which will demonstrate successful methods of implementing smoking cessation programs for pregnant women. Another example is that we have convened a panel of experts on the content of prenatal care to try and determine which is really effective in the various components for prenatal care, and we expect their recommendations this fall.

Next month we're hosting an international conference titled "Advances in the Prevention of Low Birthweight". We hope to direct attention of conference participants toward application of new research findings, and encourage them to move forward with this knowledge.

The second area I mentioned we are doing in public health is actually delivering care. We initiated several projects to provide additional resources, consulting and technical assistant to state and local communities.

These projects are designed to help strengthen the organization of services and promote access. We are now in the process of implementing Secretary Bowen's infant mortality initiative.

Our community and migrant health centers will serve as sites for providing case-managed comprehensive services to low-income pregnant women and their infants through the first year of life.

Another initiative is our cooperative agreement with the National Governors' Association. I find it interesting that the Public Health Service is actually funding the National Governors' Association to help them in adopting the Medicaid expansions.

Of course, those expansions are very important to us because the clients of our community health centers are those Medicaid-eligible women. If they are not entitled, if they don't have those benefits, it is a barrier to our giving them that care.

Each of these programs is designed to reflect a conscious attempt to help strengthen the Federal/state partnership and promote implementation of proven strategies for a large proportion of the population in need.

The last area I will mention is that which we have just been speaking of. That is collaboration. We certainly work to promote cooperation among the various entities in both public and private sectors. We recognize the importance of working within the Federal Government to get our own act together.

We have just heard that we are not collaborating with Education as well as we could, but let me give you some examples of how we are working together.

Representatives from the WIC program in USDA and from our Office of Child and Maternal Health do meet together regularly and collaborate on those programs in nutrition and MCH which are so obviously linked.

Our Primary Care Division, which runs the community and migrant health centers, has established a formal liaison with the MCH people and they meet regularly.

Let me just point out, to emphasize the commitment of the Government at present, that in the President's budget for 1989 we are requesting complete authorization, full authorization under the law, for our community and migrant health centers, and for our maternal and child health care programs, plus $20 million to fund Secretary Bowen's infant mortality initiative.

MCH collaborates with the Department of Education specifically on the Rehabilitation Act. I think I might have misled you when I told you we weren't spending public health funds on education.

For the question raised by Dean Wilson, I guess that through MCH block grant money, maybe one-third of the states' budgets for health education is funded through that.

One example that has come to my attention, Dr. Hutchins pointed out, is South Carolina. Apparently, Governor Riley, you have a very exemplary SPRANS grant that funds a health education program in the seventh and eighth grades. So that's another example of something that has worked.

Let me just summarize by saying that for all we are doing, we can do better. We are certainly standing near the front of the line and want to be an active participant with you.

We very much look forward to the recommendations of this Commission to see how we can do an even better job in our efforts.

Thank you.

SENATOR CHILES: Thank you. Now we will hear from Jeannie Rosoff, President of the Alan Guttmacher Institute of New York.

MS. ROSOFF: Mr. Chairman, members of the Commission, since it's my lot to discuss money and I think only money, and that is not a very popular topic, at this point I would like to make a couple of remarks to start with.

We don't think money is everything, but it helps. I think at one of the first hearings of the Commission, at which I was in the audience, I listened to representatives of other countries discuss their programs. Essentially, what they said is we guarantee access to all and we supplement for some.

I think the issue in our country is the discontinuity between the general access and the issue of supplementation. We realize that there are groups in the society for whatever reason, whether they are pregnant girls or whether they are immigrants, whether they are smokers or indulge in substance abuse, who will need supplementary help.

But the issue is do we guarantee access to all to start with? In addition to being supplemental, I think we recognize that it will help us to be local in nature, that each community and each program and each state doesn't get to develop its own program.

Lastly, because I'm going to report on the study which we have performed over the last two years, one of the conclusions we came to at the end is that there was money in the system, namely that 99 percent of all American babies are delivered in hospitals. They are not born in the street or in taxis. The 1 percent very often are delivered at home because their mothers wished them to be delivered at home.

So the big-ticket item, which is the hospital stay and the delivery, is paid for by somebody. It's paid for by Medicaid. It's paid for by local taxes. It's paid for by essentially a surcharge on your insurance or mine, by employers.

But it's paid for by someone.

What is not paid or is paid for very inadequately or sporadically is the cheaper aspect of the need, which is the prenatal care, which we all agree is the most important thing.

Now, the study which we performed over the last two years was intended to be an overview of all of the systems of financing maternity care in the United States.

Normally, we look at Medicaid, we look at the MCH program, we look at insurance in general but not with respect to age. We don't look at CHAMPUS and all of the programs by which people get covered in this country.

We attempted to do this through surveys of all insurance companies, Blue Cross/Blue Shield, state health commissioners, the MCH program, community health centers, migrant health centers and so on.

What we find is because of the age structure, if you will, of the population which is having children, which is essentially a young population, that population is very poorly covered by insurance, particularly private insurance.

25 percent of all women having children will have no insurance coverage of any kind. This is because most first babies are born to women under 25 and, at that age, people are either just out of school or trying to establish themselves in jobs.

Very often they have part-time jobs and even if both spouses are working the income may be very low and very often they may have no insurance coverage at all.

The Congress, in the Pregnancy Discrimination Act, tried to ensure that, in fact, insurance for maternity care be universal, but there are some very important loopholes which make that not possible.

Women who are self-insured, and that's through a group plan, very often have no maternity care. Even in group plans, there are very serious loopholes in coverage.

For example, the majority of plans have waiting periods to qualify. If you are pregnant, the months can be ticking through most of your pregnancy before you will, in fact, qualify.

There are many other exemptions that I will not mention because they are just really too complicated, but the net result is that you have a very large number of women who do not qualify under either private or public insurance, or any other program.

Many of them are picked up for prenatal care in MCH clinics or migrant health clinics, but these are insufficiently funded and many of these women go without care at all or else they go from one care provider to another and they get to the hospital having had no contact with anyone at all.

This has consequences not only to the women who obviously get care later in pregnancy than they should have and probably not as good care as they should have, but I think from the providers as well.

Medicaid typically pays only two-thirds of a doctor's bill and two-thirds of a hospital bill, which all of us being mortal is, I think, a strong incentive for us to divest ourselves of these clients if we can.

So there is a sort of shell game between providers about taking care of people who are, in fact, going to cost you money. I think this is not something that we need to be horrified about. I think it's pretty natural.

This has led many hospitals to dump patients or try to avoid taking patients who are going to be problematic, which leads many hospitals to require pre-deposits for admissions usually at six months in the pregnancy if you do not have any insurance.

If you do not have that kind of money, your only choice, I suppose, is to deliver in an emergency room and there are communities in which, actually, there are referral systems under which people are assigned in hospitals depending on what day of the week it is.

Finally I think that the hospital debt for maternity care is the largest of all sources of debt in the country. 27 percent of hospital debt is due to maternity care or the kind of cases which the Commissioner from Memphis mentioned in which the family has no insurance, the bill is $110,000, there is no source of payment, and the hospital has to eat that money, if you will.

It is not that maternity care patients don't attempt to pay their bills. As a matter of fact, they have a very good recovery coverage.

Simply if anything goes wrong with a pregnancy in a family with a very low income, there is just no way that this money is going to be made up.

Finally, because it was mentioned by Congressman Durbin that we had made some recommendations which were a little revolutionary, I would say that we didn't quite say it in the way that he suggested.

We say that if we have a commitment--and I think we do--to do something about infant mortality, and I think also to provide pregnant women when they are pregnant with the support and care they need even if they are going to give birth to a healthy baby, there are two ways you can go.

You can try to take the system that we have and patch it up as well as we can, that may improve. I think it will still be very uneven from community to community and will require, I think, major, major changes in all sorts of details of how we do things from insurance companies to Medicaid agencies.

I think it will mean that we will have to have two-page applications for Medicaid. It may mean that we have to transform a system which is intended to keep people away from benefits to a system that encourages people to use benefits, which probably means de-linking, at least for this purpose, Medicaid from welfare all together.

Otherwise I don't think you're going to get many poor people who are going to be willing to submit themselves to the indignities, if you will, of the welfare system.

So we had said, "Well, if you are not willing to do all of those things, there is a simpler way of looking at it, which is a more universal entitlement."

In 1965, we looked at our elderly population and we said, "Well, we think as a decent humane society we are going to cover all these folks." I think we could say to ourselves, "Well, as a decent humane society, we are going to cover all the women and the children who are going to produce the next generation."

So this is a choice I think we have to make. It's not an easy one.

SENATOR CHILES: Thank you, ma'am. Now we'll hear from, again, a member of our Commission, Barbara Matula, who is the Director of the North Carolina Division of Medical Assistance.

MS. MATULA: Thank you. I'm going to try to run you through Medicaid and our recommendations in four minutes or less. I know you are all ready for that after hearing some of the speakers today.

I drew on a study that is being undertaken right now by the

National Governors' Association. Ian Hill was kind enough to share a draft with me.

In that draft, they reviewed about 20 states and some of their best practices and what they have done under the enabling legislation of SOBRA 1986 and, again, 1987, those that could react that quickly to 1987.

In that report, we also looked at some of the problems that persist. I am going to make some recommendations today to eliminate some of those problems.

Yes, we went the first step in breaking the link between AFDC income levels and Medicaid eligibility, but we still have a few strings that need to be cut. Some of the problems, as you can imagine, that still exist have to do with eligibility, but there are others.

In some states, outreach efforts are ineffective. Regardless of where we look, the problems of transportation and day care remain, there are delays in getting appointments, there is an inability to speak English, a fear of deportation. The list goes on and on.

These haven't changed with expanded eligibility income guidelines.

Where the eligibility workers are located is an issue. Whether it is a state-administered program or a county-administered program may make a difference as to how quickly you can respond.

But nonetheless we hear so much about presumptive eligibility as though this is a problem-solver. In fact, there are some aspects about presumptive eligibility that can make your hair more grey than grey.

One of them is trying to develop a Medicaid Management Information System to process claims that can respond to a 5-day, 14-day and 45-day period of eligibility that can change daily for only limited services.

I mean, it would take a genius to come up with this and to follow it through.

Yet there is still latitude in the law, as it was enacted in 1986, that I think we are not taking full advantage of. I would like to make some recommendations.

Even though it is great for states and communities to act as laboratories, I am particularly upset that poor pregnant women and infants can be penalized depending upon what part of the country they live and grow up in.

So one of my top recommendations has nothing to do with Medicaid eligibility, presumptive eligibility or anything I have mentioned so far. I would like to see us make prevention of infant mortality or, let's put it in a more positive way, infant health, maternal health, a number one priority of this Nation in terms of education and outreach.

States cannot do all the outreach on their own. We are not good at advertising, but if we were we seem to shine in areas of prevalent tourism.

It would seem to me that we need a blitz that is supported from the highest levels of this country that puts the spotlight on pregnant women and children.

I have heard too many times people say we lack the will as a nation. I don't think so. I think we lack the information as a nation.

Now that yuppie mothers have discovered motherhood, maybe this is just what we need to go on. But I say that if we can bring AIDS into the public eye in such record time, we surely can do the same for the lives of our children.

That is my number one recommendation.

My number two will probably not sit right. I will probably be lynched by the other 53 Medicaid directors for saying such a thing.

There are certain options in the law that I believe should become uniform, which means mandating them ultimately.

One is that if we are going to cut 40 out of the 44 pages off an eligibility form, there should be no test of resources or assets for pregnancy care. It is absolutely the thing that drives eligibility workers crazy, verifying all sorts of things that will not pay for the health care of that mother anyway.

I think that states should not be required, nor should they as an option choose, to do a redetermination of eligibility. If the process is bad once, Lord knows it does not improve in six months.

So I would recommend that it be continuous eligibility throughout the pregnancy and for 60 days after.

I would further recommend that OBRA-1988 include in it continuous eligibility for the newborn for at least one year so that if a parent's income changes slightly in that 9 months or 11 months, or whatever period we are talking about, the providers of medical care will be assured of payment, will want to have a plan for that child, and that the child and mother are guaranteed that they will receive services for that period of time.

My recommendations about presumptive eligibility go a bit further. First of all, we know it would be simpler if we weren't doing an assets or resource test, but we need a flat 45-day period of presumptive eligibility. 5, 15, and 45 days are unnecessarily complex.

There ought to be a single form. It ought to be a form for presumptive and for final eligibility in which the signature of the applicant ought to suffice.

There shouldn't have to be a second trip to a welfare office. All you need do is verify income.

To go a step further in simplifying eligibility, the tie we have to break is the one to the AFDC methodology.

When my recipient services folks back home tried to explain to me how even though we were not tied to AFDC income, we had to be tied to methodology, I knew we had to start over again.

Let me give you two examples of what AFDC methodology means.

One is that a woman must identify the father of the unborn child in order to qualify for care unless there are compelling circumstances.

I think for purposes of receiving prenatal care, it would be an excellent idea to waive that requirement until after the birth of a child for anyone who seems reluctant to do so.

Whether or not I think AFDC methodology might do as well in one instance, we cannot decide in our state if parental financial responsibility ceases at 18 or 21. AFDC says 18, Medicaid said 21.

What we are saying here is that we are holding grandparents responsible for the care of their unborn grandchild because if there is a minor child, a teenager living at home, her parents' income is counted into whether or not she can receive prenatal care.

I think that we need to simplify and eliminate that.

If we are going to take bold steps, and I hope we will--we had some inspirational words at breakfast--I think that we ought to have an income standard, let it be 185 or 200 percent or whatever we decide, for eligibility for these services that are uniform across this country.

Whether or not we need to phase into it, again I do not believe that people or their babies should be penalized because of where they live.

During presumptive eligibility, we have run into a little minor knot. We cannot pay for everything that a woman might need during that 45-day period.

Laboratory tests, prescription drugs do not qualify. We would hope that clarifying legislation could amend that. It seems like a very minor problem.

We are trying in North Carolina--it seems to be working--that we have automatic referrals between WIC and Medicaid, that there not even be a pause, that if you are eligible for one you are eligible for the other and seen across the street or hall or wherever you need to.

They are the simplification efforts. I think that we have to look hard to reimbursement. We are not reimbursing, in many cases. Two-thirds of the rate would be a bonus in some states, if we were paying providers two-thirds of their costs.

So we have to look at that.

Our package of services really should include the things women need, be it transportation or day care. Most certainly, case management is critical.

EPSDT is wonderful. I have been a champion of it for a long time, but it has two minor problems.

Do you recall Dr. Roper saying that 11 million children were served under Medicaid when he began, but only 3 million are in EPSDT? This while EPSDT, which sounds like an immunization and should have a name change, is mandatory for the states but is voluntary for the mother.

Can you imagine sitting in a welfare office face to face, after filling out 45 pages, and having to ask a mother if she wants EPSDT? She says, "Oh, no, thank you."

That's why we have 3 million instead of 11 million children enrolled.

It ought to be automatic and certainly for our newborns.

In addition, while it goes far enough to say that you can offer any service needed to a child that is identified in this screen, many states still have limits on services.

I would urge that state plans not limit services that are determined necessary for a child.

Taken together, these are small steps, but they sure would put some of the dark back in our grey hairs.

Thank you.

SENATOR CHILES: Thank you. We now will hear from Mr. Loren Bell, a Director of the WIC program of Olympia, Washington.

MR. BELL: Thank you, Senator Chiles. It is my privilege to be here today to present some thoughts of the WIC community, those of myself and my colleagues.

I think as governmental administrators we have to grapple every day with the realities of how to implement all of the programs we have talked about today.

It is very difficult, as an administrator, to try to view these programs as comprehensive. I think we tend to view our programs either as categorical, in which case we focus on a single function of the program, or as a block grant, in which case we assume those closest to the problem will do something about it.

We rarely view these programs as a whole system. Failure to do so is the major reason why public administrators rarely ever talk to each other, particularly at the state and local level. We are too busy focusing on our own concerns.

Yet it is ironic that even though the system does not appear to be inter-related, the best way to show how inter-related it is is to cut one of the programs.

Congress and the Administration must be aware that adjustments and cuts in programs or regulatory changes in programs often affect other programs. We, in the WIC community, have been severely impacted by decreases in other publicly-funded programs that support the local-based programs through which we provide our services.

It used to be that WIC was an adjunct to health care. Now more often health care is an adjunct to WIC.

Major Government programs that serve to prevent infant mortality need to come together and do several things.

One, we have talked a lot here about eligibility criteria. Certainly simplification is one answer, but common eligibility criteria, where possible, is another.

An example of a flaw in the current system is found in WIC in which, under Federal regulations, we must count a pregnant woman as a family of one whereas, in maternal and child health in Medicaid, they are counted as a family of two.

Therefore, WIC is saying, "We will not pay for this woman to have good nutrition during the pregnancy, but once the infant is born and healthy we will start picking up food costs for it."

The second thing we need to do is declare ourselves responsible for reducing infant mortality and to redirect existing resources. By this, I don't mean taking resources from one preventive program and putting them into another one.

It doesn't make any sense at all to move funds that are helping to prevent other things into a program to prevent infant mortality when, later, those other programs will suffer.

In the WIC program, we do have a priority system, but that does not mean that the children in the program are not just as important as the mothers and infants. In Washington State, we established a Governor's Task Force on Hunger.

We discovered, much to our chagrin, that one of the root causes of hunger in our state was the fact we were taking so many young children off our program to put on pregnant women.

Washington State is the third-best targeted program in the country with relation to serving pregnant women and infants, yet a medically-at-risk child must be taken out of the program at age two even though they would be eligible until age five.

We think that programs that cause children to be born healthy should also help them to stay healthy.

Thirdly, we must base our funding priority on cost-effective outcomes. Like Commissioner Bolton, my second child was born premature as an emergency cesarean section.

Unlike Commissioner Bolton's, my child has no hearing at all. In addition, there are other neurological problems.

The costs of special education and medical expenses just to my insurance company and our school district are phenomenal to support my child. All of that probably could have been prevented.

My wife and I knew the system very well. I had been a Maternal and Child Health Administrator for ten years. My wife was a lobbyist for the California Children's Hospital Association.

Yet we had to deal with a system that was totally unresponsive to the notion of prevention and the notion that all these services should be coordinated and well case-managed.

As a result, we have gone through this situation with our daughter.

Finally, we must develop creative ways of solving the problem, but in doing so we must look at the system that is out there to absorb those.

In 1976, as Regional Administrator for Maternal and Child Health in Los Angeles, I assisted in establishing one of the first high-risk prenatal care programs that was hospital and community based that provided WIC, family planning and high-risk prenatal care services.

The program was declared a national model and won several awards. However, at the end of its, quote, funding cycle, as a demonstration project there was no system for it to fall into.

We can all cite beautiful and creative programs that we have done at the state and local levels. Yet if there is no system for that program to be integrated into, those programs are often lost to us after their completion.

Finally, I would like to make a few recommendations in terms of creative ways that we can look at things.

We need the assistance of Medicaid directors in trying to integrate prevention.

The purchase of television time, particularly during highly-watched programs, and the development of professional commercials using the technology available to us today is a far better system than the old system of public information announcements at 11:30 at night.

Mobile prenatal care clinics and WIC clinics that have actually gone out and provided services where the clients are have had significant impacts where they have been tried.

The use of private-sector technology, the area of developing marketing strategies and outreach strategies for reaching these clients, is particularly important.

The State of Oregon initiated a study using a professional marketing firm and was able to do significant things to bring more clients into their programs.

Finally, we must make the public more aware. Programs on television, such as the recently-telecast "God Bless the Child" and "A Place at the Table", have significant impacts emotionally on the American public.

It seems to me that in dealing with the issue of a life of a child we could do the same kinds of things to make these programs acceptable to the community and get the support to those people who need it to make these programs expanded and successful.

SENATOR CHILES: Thank you very much. We will now hear from Caroline Gaston, the Principal of New Futures School in Albuquerque, New Mexico.

MS. GASTON: Thank you, Chairman Chiles. Let me make clear that the New Futures School is an alternative school of the Albuquerque Public Schools. So I am speaking as a school principal at the local level.

There is a close inter-relationship between infant mortality and our teen pregnancy rates, which are higher than those of any other developed country. One out of every six children in the United States is born to a teen mother.

The infant mortality rates that I was able to find show 17.4 per thousand for children born to a teen mother. In order to be effective, I think we have to address teen pregnancy on a broad front. We must reduce the teen pregnancy rates and we must reduce the negative consequences for those who do become pregnant. It cannot be either one or the other.

I think we have to work on both in order to have an effect. That means that the school systems must be involved because schools are where most of the teenagers are, but not all.

We wish more of them were in schools, but we must address, through the schools, those who are in school.

There are a number, now, of successful models for preventing teen pregnancy. By "successful", I mean that they have reduced the measurable teen pregnancy rates in those communities where they have worked.

These national models, which I cited in my written testimony, all involve, with the exception of one program, a cooperative effort between the schools and the community.

It is not easy for schools to work cooperatively with the community. They don't have very much experience in doing that. But I think it is essential that they do it if we are going to have an impact upon young people.

I am not talking about just the sex education model. We really have to address our young people in a much broader way.

We have to look at issues that are much deeper to young people.

How do they feel about themselves? How do they feel about their role in the community? How do they feel that they are going to find a role in the community or are they going to find one?

You don't plan for the future if you don't think you have a future. Unfortunately we have a number of young people in our country who don't really think they have a future.

Therefore, talking to them about "Just say no" or "Think about how this can impact upon your future if you get pregnant now" doesn't mean that much to them.

We have to address it in a much deeper way to make them feel better about themselves.

So the schools are involved in teen pregnancy whether or not they like it or whether or not they plan to be. A student who fails a grade in school is much more likely to become a teen parent than a student and the peers who are going on.

Schools have a major influence on how young people feel about themselves. Are they a part of a world where they are going to have a place, or do they see themselves as hopeless?

I would urge all of you, if you have not had the opportunity to do so, to read the book that Mr. Harris referred to yesterday evening, Children in Need: Investment Strategies in the Educationally Disadvantaged.

You will find both the Beethoven Project, that you visited this morning, and New Futures School listed as model programs in that document.

When a teenager does get pregnant, the schools still have an important role to play because that teenager needs to continue or to re-enter the educational process.

The education that they find when they go to school as pregnant teens or as teen parents must include, in addition to the academics, parenting education, on-site health care, health instruction, counseling.

In general, in order to do that requires on-site child care. One model for this is New Futures School in Albuquerque. Let me describe that school a little.

We are an alternative school of the Albuquerque Public Schools, but we are also a community agency. I am a principal for the school system. I'm an executive director for a community agency.

Therefore, it is the schools and the community working together. We provide ongoing education, but we also provide health services. WIC comes to our building. Maternity and child health services through the university comes to our building.

We are providing all of these services on site and we are providing them in a way that makes young people feel better about themselves and more responsible for taking care of their own health.

In my testimony I cited some positive outcomes.

I would hope that one of the recommendations from this Commission would be that school systems will be urged to work with community agencies cooperatively to help to prevent teen pregnancy and to provide services that improve the health outcomes for pregnant teens, and teen parents and their children.

Thank you.

SENATOR CHILES: Thank you very much. Now we will hear from Mr. Frank Ellis, Jr., President of Swope Parkway Clinic of Kansas City, Missouri.

MR. ELLIS: Mr. Chairman and members of the Commission, thank you for inviting me here today. I am E. Frank Ellis, Jr., President of Swope Parkway Health Center.

I welcome the opportunity to address such an impressive audience on such a serious matter as infant mortality.

My comments will be brief in describing the resources of Swope Parkway Health Center to address infant mortality in our community, a specific program targeted towards higher-risk pregnant mothers, a case study, and some concluding remarks with some specific recommendations.

Community health centers play an important role in identifying the health care needs of the communities and neighborhoods which they serve and in developing services to meet those needs.

Health centers fill a gap in the health care system by serving low-income and indigent persons who otherwise have difficulty receiving appropriate and timely care through other avenues.

Community health centers provide a broader scope of services than private physicians would. In 1980, Swope Parkway Health Center also was designated a mental health center grant enabling the expansion of outpatient services and the development of inpatient day treatment, counseling and education.

The Brookside Mental Health Office, as a satellite, opened the same year.

In 1981, the health center was designated by the Department of Mental Health as a full-service center and administrative agent for that service area. In 1984, an HMO organization for Medicaid recipients was developed and implemented.

That same year, Swope Parkway Health Foundation was incorporated to serve as a fund-raising arm for the Center. The Center is a United Way agency and is accredited by the Joint Commission.

We have assumed a leadership role in the community, along with other perinatal providers, to address these concerns. We have established a community health project to provide medical and social services to high-risk mothers and infants with emphasis on home visits, transportation services, smoking, drug cessation, nutritional classes, counseling and education.

The project concentrates on reducing infant mortality and low birthweight among pregnant Black teenagers, a group known to be at high risk.

It is a community-wide effort, including major perinatal providers working with a variety of funding sources including the county government, United Way and March of Dimes.

In addition, because of the enormity of the problem in Kansas City, a SPRANS grant has recently been submitted to BHCDA. In addition, perinatal classes, parenting classes and nutritional classes are offered on site. A WIC clinic is also available on site.

The Center serves, also, and staffs two Robert Wood Johnson funded high-school-based clinics. These clinics work closely with teenagers who have a variety of social and economic problems. Many of these teenagers are pregnant, as well. These activities give you a few ideas of the leadership role that the health center has taken with the tremendous support of other health providers and funding partners.

Kansas City has the dubious distinction, as noted by the Department of Health's State Center for Health Statistics in their February 9th report, of being the leader in both infant mortality rates and in low birthweight for Kansas City. That is over and above St. Louis, Missouri.

Many factors contribute to the higher rates of infant mortality in the population that we serve. Culture, ethnic, family background can interfere with a pregnant woman seeking health care.

Other barriers include mistrust of agencies in general, a lack of financial resources, and a lack of knowledge of community resources.

These young pregnant women offer minimal understanding of the deleterious effects of how smoking, drugs, alcohol and multiple pregnancies in a short period of time can affect their health and that of their developing child.

The following is a case study of the complexities of the needs of many of our patients. KR, a 16-year-old woman, came to the OB-GYN Clinic at Swope Parkway Health Center on October 14, 1987 complaining of vaginal infections. On examination, she was found to be 20 weeks pregnant.

Cultures for gonorrhea and chlamydia were positive, and antibiotic treatment was started. Her history revealed that prior prenatal care had been limited only to a testing site visit in early August for a pregnancy test.

On risk assessment, KR admitted to using crack and stated that her boyfriend was an IV drug abuser. She denied use of alcohol and IV drugs, but has been a two-pack-a-day smoker for four years.

She was lost to follow-up care until November 1987 when we were notified by the local emergency room that she had been admitted for head injuries believed to be the result of physical abuse.

She was readmitted in January 1988 and had a C-section delivery of an infant weighing 1300 grams. She failed to return to the health center for postpartum care.

The challenges of infant mortality and low birthweight must be viewed in a larger context as well. 35 million Americans live below poverty, but do not meet the guidelines for Government or private health insurance. This group includes spouses and children of employed persons and under-employed persons not covered by insurance.

One out of four, or 25 percent of the 35 million, are children who will receive inadequate care or no care during their lifetime, thus carrying the tragedy into a new generation.

A comprehensive resolution to this complex and serious problem should be initiated immediately. To do so requires maximizing the use of Federal, state, county and city government funds which would necessitate a strong commitment to coordinate the efforts on all levels.

For example, Federal existing Medicaid matching moneys could be mandated to require states to coordinate their resources with local resources to place the problem of infant mortality on a higher priority level.

Such commitment on the part of the political system would enable mental health, drug, alcohol, transportation, social services, and education agencies and departments to focus jointly on this issue.

In addition, the private philanthropic community should be approached on a larger scale than in the past to solicit their cooperation in working with both community health centers and other public and private agencies.

Simultaneously, every effort should be made to promote the recognition of front-line primary health care providers, business, civic, philanthropic and social groups of the deleterious effects of low birthweight and infant mortality.

Finally, Mr. Chairman, we recommend that both Federal and state agencies take the leadership in developing an ongoing advisory committee composed of front-line primary care organizations and business, civic and philanthropic, to propose strategies to address this increasing problem of low birthweight and infant mortality.

Thank you.

SENATOR CHILES: Thank you. Our next witness, Sister Jeanne, is a lady that believes in a hands-on approach. She delivered five babies yesterday as a nurse midwife. We are delighted to have her here. [Applause]

SISTER JEANNE MEURER: Thank you, Mr. Chairman. I'm delighted to be here. As you said, I am a practicing Certified Nurse Midwife. I have been working for the past 18 years taking care of poor, needy pregnant women and their children.

I feel the issues we are going to talk about today are extremely important. I would like to give you the viewpoint of a health care provider who is taking care of these women.

I would like to tell you about a successful program that we initiated with Federal moneys in Florida. This was migrant moneys and community health service monies.

The care that was provided at our center was comprehensive. I must tell you, Ruskin is a very rural little community about 25 miles south of Tampa. We raise strawberries and tomatoes.

In our market, people who pick are migrants. About one-third to one-half of our population are migrant people.

The care was provided by a group of certified nurse midwives with the consulting physicians as back-up. It was a comprehensive case-managed type of care where we had everything from child-birth educators to outreach workers.

I believe that the excellent outcomes that we were able to demonstrate were because we had comprehensive continuity and quality care. That was our goal standard.

There was management at all levels. The care was continuous because they had consistent health care providers by nurse midwives.

The secret in our program was that we taught mothers to be responsible for their care. We had an outreach program that was aggressive.

I sometimes tell my friends I would threaten them if they wouldn't come in for an appointment I would come and get them myself, but beside that they knew if they wanted a nurse midwife to deliver them, they had to stay healthy.

I think that's important.

I must say that most of our women were poor, young, with little education. Most of our families did not have running water, heat or electricity.

We were able, after 15 months of operation, to reduce the low birthweight rate to 3 per 1,000. In contrast, the State of Florida was 8.1 and the county we reside in was 8.2.

I think the reason for the success I have already described was continuous comprehensive case-managed care with an excellent support staff.

I would like you all to think this is continuing, but it isn't. In that program the moneys were cut. After one year from when the program was cut, we have gone right back up to the same rate as we were before the program.

In dollars and cents, we estimated that in those 18 months we were able to save 25 low birthweight babies. We used the lowest figure possible of $15,000 per newborn. That was in 1984, and that is very low.

We estimated we saved the county $375,000. That is very little in comparison to just a neonatal intensive care nursery.

There is a question I would ask the Commission and everybody here. We have a good program and the moneys are cut. Why do we have to continue to cut good programs that have demonstrated themselves.

That is my concern. We don't need another demonstration project.

We know what a good program is.

Let us put our money to replicating good programs that have already been demonstrated.

Finally, I would also like to support the concept of case management. It's clear that states can now choose or not choose to reimburse for case management.

We know the cost-effective savings in case management. Let us make it imperative that we have case management across the board. I might say case management within a public health nursing context I believe is important.

I think it is so important that money alone is not the answer. I think the program that failed in our area was because we did not have good administrative consultation from the Federal/state level.

We needed good consultation and could not get it. We needed people who had the experience.

I have nothing against good community boards, but you have to have people who know good administrative and economic policy. When you do not have that, your programs are bound to fail, without that type of support.

In rural areas, I think we have to realize that nurse midwives and nurse practitioners cannot work alone. They need adequate medical back-up.

We need good transportation and care services. You cannot get to a clinic or you may not have a car.

I thank you for this opportunity to tell you the story of poor mothers and babies. I would like to leave with a quote that I found that has carried me through for a long time from one of the outstanding poets of our century. He said:

> The child cannot wait.
> Many things we need can, but he cannot.
> To him we cannot say tomorrow.
> His name is today.

Thank you, Senator.

SENATOR CHILES: Thank you, Sister Jeanne.

[Applause]

Now we will hear from Diana Robinson, a Family Advocate of the Center for Successful Child Development. That's the Beethoven

Project that we visited this morning.

MS. ROBINSON: Thank you Senator, Governor, honored guests, and distinguished members of the Commission. I am here to speak on behalf of the babies born and those yet to be born to the women of my community, the Robert Taylor Homes.

This is a community where less than 20,000 residents are forced to live in an area that totals less than two miles. Of the 20,000 residents, 69 percent are children.

Many of these babies face an uncertain future as they enter the world without the benefits of proper prenatal care, low birthweight and the lack of even basic necessities that are crucial to their development and survival.

These babies will grow within a community where poverty and despair is quite often a way of life. They will inhabit buildings that are unsafe, poorly maintained and ventilated, roach and rat infested, and where there is little room afforded for normal play.

The question before us today is what is Government's role in reducing the growing number of low birthweight babies? Government programs, such as WIC, that have been funded to promote healthy diets among pregnant mothers and their infants have lost sight of the human aspect of those they serve.

Many times pregnant mothers and mothers with small infants that they must bring with them to the WIC offices are forced to wait for hours for the coupons. This further increases their frustration and frequently causes mothers to give up, thus not receiving this important and necessary service.

For some who are successful in participating in the WIC program, they are often penalized. Babies who gain weight too quickly are not allowed to continue receiving the added help.

This situation only causes mothers who cannot afford to purchase the very products that are important to the bone development of their babies to exclude milk and other forms of calcium-enriched food supplied by the coupons from their children's diets.

Pregnant moms who do receive WIC coupons often have other children in the home. These mothers have little choice but to use what is purchased with the coupons to supplement the already-poor diets of their other children, thus leaving very little if any for their own consumption.

The AFDC is yet another Government-sponsored program that has lost sight of the human aspect of those they serve. Here, again, those who come to AFDC offices in search of some relief from the poverty they suffer are only met by over-worked hostile care workers who only serve to add to the humiliation that engulfs the lives of the poor.

Women who are hungry and in need of emergency food stamps to purchase food for themselves and their children are often forced to wait anywhere from 30 to 60 days until their case has been considered.

Another influencing factor is the environment residents are forced to live in and rear their children. In the battle over who shall control the management of public housing, the only losers are the residents and their children who are now even denied the right to properly maintain safe and affordable housing.

The list of the inhumane treatment suffered by the poor goes on and on.

How can we, a so-called just and humane society, continue to ignore the cries of the innocent? Until we, as a society, take responsibility for the problems of the poor, their despair will continue to eat away at the very fabric of this great Nation.

It is, therefore, my belief that it is our shared responsibility to promote and to aid social agencies and programs that work, and to redefine those who have lost sight of their purpose in their efforts to bridge the gap of despair for the children born into poverty.

We must work together to ensure that their cries are consoled, that their hopes for the future give way to triumphs, and that their fears are quieted with compassion.

Thank you.

[Applause]

SENATOR CHILES: Thank you.

We are going to go into our questions in just a minute. We will take a brief recess before that.

[A brief recess was taken.]

SENATOR CHILES: We will turn now to questions and answers.

Sister Jeanne, what are the problems of those who need to have these services reasonably close to their homes?

SISTER JEANNE: I think one of the big problems that we have with that issue is that getting professionals to live in very small rural areas is very difficult. If the professionals do not live there, they are going to have to commute 40 or 50 miles a day to the health center, which some of them do, but then they expect to be reimbursed for that.

The other issue with that is, though, most professionals--and I will talk about physicians first and nurse midwives second--also like to have hospital privileges. When you are working in a health center and you do not have hospital privileges, part of your life line is cut from you, your professional practice. So that becomes an issue.

The third point I would make is that when you are working in rural areas--and I can speak better to the rural issue--we are talking about high-risk women. Their care is expensive.

You cannot deliver that type of care without good technology, without good medical back-up. Regardless of whether you are a nurse midwife or a physician, you have to have appropriate laboratory services, ultrasound if it is needed, non-stress testing if you want to have good outcomes.

The initial outlay is expensive, but the long-term results produce a great saving. That is where I think we have a hard time influencing our policy-makers to make that decision.

Just to summarize, I think it's very difficult to get physicians and nurse midwives to go to a rural area. They will do a two-year commitment and then leave, and then we start all over again. Then it is a reorientation of a culturally-sensitive approach to that type of care in a rural area.

Otherwise, their wives or husbands don't want to come or cannot find a position. So it is a multiple group of problems we are dealing with.

SENATOR CHILES: Mr. Ellis, is this problem evident in the inner city?

MR. ELLIS: Most definitely, sir. One of the major problems is that for most of our physicians--even though our staff is full time, we do not allow outside practice, we are so heavily dependent on the National Service Corps--once they have completed their obligation, it is very difficult for them to have role models to want to stay in the central city.

Oftentimes, our education system for providers is such that while they do their residencies in the central city on patients who live in the central city who are less fortunate, once they have completed their training they go out to the more lucrative practices.

I cannot over-emphasize the necessity for involving the private practitioners. I think our private practitioners have a definite role to play in having a responsibility for taking the knowledge that they have gained from practicing in the central city and then carrying that knowledge or commitment back for the duration of their practice.

Once they have completed their training, they take that expertise into the more affluent areas of practice and we never see them anymore.

DR. HEIN: Could I follow that up with a comment, please?

SENATOR CHILES: Certainly.

DR. HEIN: Thank you, Mr. Chairman. This is just a comment to follow up with what Sister Jeanne had to say.

Like you, Sister, I come from a very rural area. For the past 15 years, I have had the experience of developing a regionalized system of health care.

A lot of the flak that I have taken over the years is because I have always stood up for the small hospital.

We have demonstrated, in Iowa, that you can develop a very strong system of rural health care that provides a high quality of care. In our littlest hospitals in the state, those that deliver fewer than 500 babies, our neonatal mortality rate is only 1.7 per thousand.

But it must be underscored that that is predicated on the fact that they are tied into a regionalized system of care.

We have found exactly what you said. When the small hospital cannot make it, eventually only the oldest of the group of physicians will stay. You cannot recruit new physicians to the area.

I think you have put your finger on a very important part of serving rural areas, maintaining the small hospitals. Although they initially don't seem to be cost effective, in truth I think they really are cost-effective.

I had a second point to make to Mr. Ellis. In your testimony, you lamented the fact that the mortality rate in Kansas City had gone from something like 12.5 in 1984, 11.6 in 1985, up to something like 16-something in 1986. That certainly is an alarming figure.

But one thing I would caution about in interpreting those figures in major metropolitan areas, sometimes in truth a regional system has taken effect such that many high-risk mothers from an area will be brought into an area, such as Kansas City.

So you want to analyze those data very carefully. In fact, the increase of a mortality rate may, indeed, be a salutary thing within the region.

I don't know if that's true in your case or not, but it is possible.

MR. ELLIS: Actually that's one of the issues that was addressed in our advisory committee for preparation for a SPRANS grant, to actually analyze some of the trends that you are referencing.

DR. HEIN: Yes.

SENATOR CHILES: Good point.

MS. ROBB: I have a question for Ms. Gaston.

In reading all about your program and your school, it's very exciting.

How old are the students when they come to your alternative school, and how long do they usually stay?

MS. GASTON: We are a junior high school as well as a high school. So we have students as young as 12 years old on up to 20 years of age. One-third of our students are 15 or younger.

We, of course, like to get them early in the pregnancy because we can have more effect at that time, but we taken them whenever they come, including some who come already as mothers, because we can have an impact on the parenting skills.

The average length of stay would be about a school year, but some stay longer because they just don't have any support system to go back to their regular schools. About half of them had dropped out of their regular schools for a period of time before they came to us and they are not likely ever to return to a regular school.

So we kind of judge that individually and provide the support for as long as it appears it is needed.

MS. ROBB: One of the great problems is there are so many young mothers who cannot go back to school even if they wanted to because they need child care for their babies.

They can stay in your school and get the child care on site as long as they remain students?

MS. GASTON: That's true. As long as they remain students, and that means they have to be passing classes. They are responsible for helping to take care of children in the day care centers.

It is a cooperative thing. So they are learning parenting along with assisting the schools to keep going.

By having the day care on site, I think this is one of the primary ways to indicate that nearly half of our young mothers choose to breast feed, because they can do it when day care is right there. We believe that is a very positive thing.

MS. ROBB: But if they are already a mother, if they have dropped out of school to have a baby, they can enter your school and you will have child care for that child.

MS. GASTON: Yes, they can. They can apply.

We have had a waiting list for those day care slots all year, but they can apply. We take the most needy.

Let me clarify the point about dropping out. We find that 40 to 45 percent of our students had dropped out at some point in time. About half of those became pregnant, dropped out of their regular school, and then chose to come to us.

The other half dropped out of their regular school, found nothing much to do in their lives, became pregnant.

So I think we are seeing that about 25 percent of the pregnant teens have dropped out of school first and then become pregnant. There appears to be a very close relationship between teen pregnancy and the whole drop-out issue.

SENATOR CHILES: What can you tell us about your repeat rate in your pregnancies? What success have you had?

MS. GASTON: We think we have had good success.

We follow up every year and then also have an outside evaluator do long-term follow-up studies. The average repeat pregnancy rate at one year postpartum is 18 to 25 percent.

Our rates have varied from 6 to 11 percent over the last ten years.

MS. ROBB: How many students do you have in your school?

MS. GASTON: Right at the present time, we have 250 students enrolled in the school and they are all either pregnant or parents.

MS. ROBB: That ranges from?

MS. GASTON: 12 to 20.

MS. ROBB: From what grade?

MS. GASTON: Grade 7.

SENATOR CHILES: What percent of the need of your community are you meeting with your school? Are you meeting it all?

MS. GASTON: It's very difficult to tell because of the issue that was raised. We know that a lot of people come in from outside of Albuquerque to have the baby delivered in Albuquerque.

We think we are meeting well over half of the need. Very few of our students in our particular population--and we are serving primarily a Hispanic population--remain in their regular schools during the pregnancy.

They are dropped out or they were already dropped out and they are not coming back. We think we are probably serving well over half, but certainly not all of them because we don't provide transportation and we are a large city in terms of area.

They have to get themselves there. Many of our students are riding an hour each way on two or three city buses to come to us and then reversing that at the end of the day.

So they are demonstrating a commitment to education, but it's hard for them to get there.

SENATOR CHILES: Governor Thompson?

GOVERNOR THOMPSON: Mr. Chairman, I wonder if Mr. Bell has encountered criticism of the WIC program that I have heard that administrative expenses are outstripping administrative resources and there needs to be more flexibility on the part of DOA in that.

If so, I wonder if Mr. Bode could respond.

[Laughter]

I would also like to know if Mr. Bode would respond to the testimony of Ms. Robinson about the more you achieve in getting your child's birth weight up on the WIC program, the sooner you get taken off.

MR. BELL: Certainly. Yes, we have experienced that.

When the WIC program was initially established, it was viewed as a broad continuum of care, that you identified these pregnant women, infants and children who are at medical risk, and then you kept them on the program to try to prevent them from having ongoing problems.

I think the example Ms. Robinson gave--once the child is healthy you take them off, they become unhealthy and you put them back on again--is the kind of cycle that we have looked at.

But the original intent of Congress was to keep the administrative cost at an 80 to 20 ratio, 80 percent food, 20 percent what they called administration, which really is eligibility determination, nutrition education and the development of the data systems we need to be able to do all our Federal and state reports.

Since then we have had a significant increase in regulatory requirements, particularly related to grocers. In addition, we have really tried to move to higher-risk clients.

The clients we have now, in some cases, are very typical of the case example you heard, a pregnant woman who is on drugs or who has significant alcohol problems or has a history of child abuse and neglect.

There are not that many resources out there that we can hook into with these clients. So we tend to try to help them the best we can.

In doing so, seeing the higher-risk clients has increased our administrative costs significantly just because of the complexities of the problem.

In the State of Washington, I was able to convince our state legislature that our administrative budget needed augmentation because of that very fact, that we would not be able to use all of our available Federal food dollars if we were not allowed to have additional funds to meet the demands that the local agencies are providing.

In addition, for a number of years local agencies in Washington have contributed between 20 and 30 percent of the costs of the program just in order to be able to continue the service level that they had before.

That, often, is not reflected in statistics where they say WIC is a 100 percent federally-funded program. Try telling that to a county health commissioner. They will laugh you out of their office.

[Laughter]

So we have had that increase. It is a problem that we are very concerned about.

ASSISTANT SECRETARY BODE: Thank you, Governor.

[Laughter]

First of all, I think the point that was made earlier about a child gaining weight too quickly and, therefore, being taken off of the WIC program is a reflection of the WIC priority system operating.

What we are talking about here is a situation where a child over one year of age is determined initially to be eligible because some medical indicator reflects a nutritional risk, such as anemia.

In that situation, of course we have a relatively high priority case, Priority III in the WIC program, and that child is served through the WIC program.

What we have after a period of receipt of the special supplemental food program is a child's medical condition improves, those medical problems are no longer present, there may or may not be a dietary risk problem where there is poor dietary intake, and that means the child is lower on the priority list.

Then it's a question of if those dollars, through the WIC program, are better used to serve an infant who does not have medical risk, but has dietary risk factors. In our priority system, the infants and the pregnant women are clearly a higher-priority group than the children.

There is the distinction between medical risk as a grouping first, and then nutritional or dietary risk as an indicator of nutrition risk problems.

With respect to the administrative funding issue, we do traditionally say that the WIC program is a federally-funded program. That is because of the requirements.

Some states are doing, as Washington is and as Illinois is,--and we appreciate your contributions, Governor Thompson--to bring state resources to special supplemental food programs. All states are not doing that.

Many states are not. They are not contributing to the WIC program food dollars, and some have varying levels and some low levels of commitment to assist with administrative resources.

In the legislation, the statute reflects a 20 percent limit on administrative funding for the WIC program, which is a federally-funded program. I guess I should note that while there are some significant reporting requirements, in particular, -- because we are interested to see that the resources be targeted where the greatest need is--the WIC program has a relatively light Federal regulatory burden, especially for a program traditionally considered as an all-Federal program in funding.

So there is always that matter of working with the state directors, as we have a good deal lately, in structuring our regulatory requirements. But I don't see any immediate shifting down in the relatively light administrative burden we have on states now.

One other point. It was asserted that there is a 30- to 60-day wait for emergency food stamps. I guess I can never say that that can't happen, it will never happen, because all too often we know of cases where the rules are not followed.

But let me say that that is a blatant disregard of the food stamp statute and the food stamp rules. Where emergency food stamps are needed, the Federal requirement is that they be provided within five days. In some states, that is not a real large percentage.

In all other cases, the application must be processed within 30 days of receipt of a signed application with the address.

We are pleased that the food stamp program, among major Federal programs, is one of the most responsive we think it should be.

SENATOR CHILES: Barbara?

MS. MATULA: Because nutrition is such an important part of the pregnant woman and the infant's development, would you mind my asking what the priorities are?

I hope there are not three or four, but do you know?

ASSISTANT SECRETARY BODE: There are 42.

[Laughter]

No. It will not take me long to go through it quickly.

Pregnant women and breast-feeding women and infants we have documented as a nutritionally-related medical condition is Priority I.

Priority II is infants of women who participated during pregnancy or of women who did not participate but could have.

Priority III is children with documented nutritionally-related medical conditions.

Priority IV is pregnant women and breast-feeding women with infants at nutritional risk due to inadequate diet. Dietary risk is rather broadly defined. There is a good deal of state discretion in defining dietary risk.

Priority V is children with inadequate dietary patterns.

Priority VI is postpartum women.

Priority VII is state-agency option. Here, again, we have a good deal of state discretion. It is previously- certified participants who might regress in nutritional status without continuation of certified food.

MS. MATULA: So there seven categories.

ASSISTANT SECRETARY BODE: Yes.

MS. MATULA: When I read your testimony last night, and I looked for it today again, do you feel that your food assistance programs are mature and adequately funded and yet a child at risk level three--

ASSISTANT SECRETARY BODE: What we are talking about is at Priority V. In the case we just talked about, the child moved from Priority III to Priority V.

What I was referring to is increased funding in the WIC program should not be billed as a way to have a major effect on infant mortality in this country. It is not going to when infant mortality is measured by deaths below one year of age and our services are pretty well covering that population at this time.

SENATOR CHILES: I would like to find out if everybody else agrees with that.

[Chorus of nos.]

MS. MATULA: Mr. Chairman, not when they are asking Medicaid to supplement the WIC. Cannot be.

ASSISTANT SECRETARY BODE: The medical risk for pregnant women, breast-feeding women and infants is Priority I. I don't know of any situation where Priority I is not covered.

Then we move down to Priority II. I am not going to redescribe the priorities.

Our medical risk factors should be covered with sufficient funding to cover those. There are always situations where administration is not covering them all, but the resources are there.

SENATOR CHILES: That is what I was trying to understand for all of us.

I think you are saying that there should be sufficient funds that we ought to be covering Priority I.

ASSISTANT SECRETARY BODE: And lower II.

SENATOR CHILES: And lower II.

ASSISTANT SECRETARY BODE: Let me say that everyone at medically-measured nutritional risk.

SENATOR CHILES: But the way now that we are administering the program, whether there are cracks out there or not, are there people who are slipping through that crack?

ASSISTANT SECRETARY BODE: I think we have medically-measured nutritional risk for women or infants.

SENATOR CHILES: But you are talking about somebody who has applied for it.

ASSISTANT SECRETARY BODE: Yes. There are situations where someone does not apply. Even below the poverty line, we have situations where people have not applied and are not receiving the assistance.

We do have an outreach program for that effort.

MS. MATULA: If I could, one last question.

How frequently does a person have to reapply for WIC benefits?

ASSISTANT SECRETARY BODE: It depends on the characteristics of the individual.

MS. MATULA: Would a pregnant woman be entitled throughout her pregnancy and for some point after?

ASSISTANT SECRETARY BODE: Throughout her pregnancy and some point after, yes. Subsequent to birth, there should be a recertification.

SENATOR CHILES: General?

MR. BOWSHER: In one of our previous meetings, we had representatives from other countries. I think somebody described here quite well that some of these other countries that have moved ahead of us and have a better record here tend to have a program that guarantees access to all and then supplement for some.

As a builder program in that supplement for some, it seems to be much more simple than ours. Today some of the people, including Barbara, mentioned some of the ways that we could possibly simplify some of our programs, including some of the Federal initiatives.

I was just wondering if the Federal representatives here could comment on some of those ideas as to whether or not they think we could simplify the access to our programs in this country to get at this problem a little better than we have maybe.

ASSISTANT SECRETARY BODE: Quickly on the food assistance aspect, I think we have guaranteed to all through the food stamp program where services are provided to all people with income below 130 percent of the poverty level and in need.

In addition, there is the special supplemental food program for women, infants and children that we have already talked about, that is intended to be a supplemental food assistance effort.

DR. ROPER: If the question was can we simplify administration of programs, surely we can. We sit here as evidence of the fragmentation of Federal programs.

[Laughter]

My good friend, John, and I are in separate departments, but it can be brought together despite the conflicting congressional jurisdiction.

Senator, I believe the major impediment to merging these is a congressional rather than an administration one.

But, anyhow, it can be bridged. I talked with you in my testimony briefly about the things we did in Jefferson County, Alabama to bring the programs together. If I could just take a few more minutes on that, Dr. Hutchins is quite familiar with the program in Birmingham.

Since 1980, all women below 185 percent of poverty have been eligible for free prenatal services, delivery services, well-child care, an integrated WIC program, family planning program, all of the things--and it is surely not because of me, but a lot of other people--that make that an exemplary national program.

Having said all that, and it is something that we are all intensely proud of, I called last month and the infant mortality in Jefferson County, Alabama is 12 per 1,000 live births.

I'm not here going to defend the status quo. Heavens no. I want to change a whole bunch of things.

But I would hate for you on the Commission to go away thinking that we could wave a magic wand and get all the smart people together, and only if there was enough money in the world this problem would go away.

It will surely not. As the gentleman from Kansas City pointed out, there are some terribly complex problems involved in causing our intolerably high infant mortality rate.

Now, please hear me out. I am not citing the woman on crack as evidence for inadequate Federal funding of programs. But, hear me out again. The fact that there are problems that are, I think, beyond public service announcements on television should not get in the way of our saying we are going to do all the things that need to be done to deal with the problem of infant mortality.

It is a terribly complicated problem and needs a lot of things done to solve it.

Excuse my sermon, but changing in a fundamental way our health care financing system may or may not be a good thing to do. We can debate that another time.

But I do not believe that that is instantaneously going to solve the infant mortality rate problem in America.

MS. ROBB: Just to follow up on that, I was on the Southern Governors' Task Force in our project on infant mortality.

One of the things that we constantly found we had a real problem with was the fact that Medicaid would not refer those women to WIC, the coordination between the two.

I would like the WIC and the Medicaid people to talk about that.

DR. ROPER: It may happen in some states. It sure didn't in ours because the same agency operated the two programs.

MS. ROBB: So if I came in there and qualified, you would just automatically hand me my food stamps.

DR. ROPER: No, no. Food stamps is another program.

MS. ROBB: My WIC vouchers, I meant to say.

ASSISTANT SECRETARY BODE: Yes, ma'am.

COMMISSIONER BOLTON: It's been interesting to listen to the problems that many of the advocates for high- risk mothers and children, and various other social service delivery systems are experiencing.

I think it's important to make this point at this time. How do you develop a delivery system that is scientific in terms of the needs of a family, not just throwing the seeds out there, to compare it to baseball, measuring the system by how many swings you take at the ball, not by if you move the runner from base to base or hit a home run?

That is why in Memphis and Shelby County we are working on a system which coordinates all of these things to make sure that after we finish spending the money we have some home runs.

We analyzed our local social service and low-income safety-net programs. We found out that in Shelby County, alone, we were spending $502,188,156 on 200,000 poor people, and none of them were moving out of poverty. This doesn't include mental health or criminal justice.

We found that to be very, very, very exasperating.

What we are trying to do now with the pilot program is to see how we can develop making use of prime time exposure for the programs, using optional programs in the schools.

We have a program similar to yours in our school system. We are using local, in-the-neighborhood health care systems and all of the things that have been talked about today.

How do we, through case management, develop a delivery system for a family that will save their children so that they will not continue to remain in poverty, so that they will have some hope, and indeed so that we can reduce ultimately this half a billion dollars that we are simply throwing in the wind and actually move the family from the first base of self sufficiency to second base, to third base, and finally home?

Not with the parents, necessarily. We have to support them, of course, but we are focusing on the children to make sure that they get to first base because that is the only way they can get to home plate, speaking parenthetically.

I think it's important for the leaders such as are here with us today to understand that that's the challenge here in America today, to come up with a transfer payment delivery plan that will move the runner around the bases of life to self-sufficiency.

That is what the people are looking for.

Otherwise, in a few years this $502 million may be $5 billion and we are still not saving any families.

So I encourage you to continue to work on behalf of your constituencies,--at-risk mothers and children, welfare families and the like--but also to encourage Government to put together the resources and the high technology that we use now to explore space or to do all of the other things that we are doing to create a better America and create some hope among the many families that we have in America who have no hope and who have really nowhere to go for the solutions that they cannot find for themselves.

ASSISTANT SECRETARY BODE: Ms. Robb, to quickly answer your question, it is really a matter of state discretion. States have the flexibility generally to do that coordination. We assure that they have the flexibility through the WIC program and we encourage it greatly.

As often happens at these sorts of meetings, the folks who are here are doing a good job and that is why they are here. There are others who are not doing as good a job of coordinating WIC and Medicaid and other services.

DR. HEIN: I would like to tap the resources at the far end of this table in the persons of Sister Jeanne and Ms. Robinson.

Using you as two examples of people who deal with the underprivileged, A, in an urban setting and, B, in a very rural setting, let's play a little game of what if?

What if we had a sensitive health care system in each of your areas? There were no restrictions to access for prenatal care or for services for infants and young children. There were no financial barriers.

How readily would the people in each of your areas access those systems? If the answer is there still would be quite a shortfall, what might the Commission consider to help reduce that shortfall?

Sister Jeanne, why don't you answer first.

SISTER JEANNE MEURER: The what if is very enticing. That what if would have to have a few more conditions, though.

It would have to be easily available especially in a rural area. If you have to travel 25 or 30--

DR. HEIN: No. I'm assuming, as I said, there are no barriers to access there.

SISTER JEANNE MEURER: Okay.

You have culturally-sensitive people who can speak the language. You have a good outreach program which is willing to go into the camps and into the fields to get them.

You have health care providers who really know and can speak their language, I mean not just a few medical words but who can really communicate with them.

Then the people would come. They want to come, but it's not just medical care they are asking for. I think that is the thing we have to remember.

In a system of care, it's not just medical care. It is all the social support systems they also need.

Dr. Hein, what would help us is if, in our centers, we would have primary health care providers just like in the old days. You know, I have been around for a few years.

I practiced nursing for 35 years so I still can remember a family doctor. You have to have a primary person to identify with when you have to go from WIC to the nutritionist to the social worker to the physician to the nurse, to this to that.

When you cannot read or write, that is where you really get lost. I guess I will go back to case management again, I'm so sold on it.

I have somebody I can identify with. I need that as a professional, too.

MS. ROBINSON: Doctor, referring to your "what if", I was thinking about the Beethoven Project. In a way, that is the what if.

The only thing about it is that it is targeted in six target buildings. It is an experimental thing.

In the 20-odd years or more that I have been around the Robert Taylor Homes, I have never seen a social agency that has been able to come into the community and take such a hold on it in the short period of time that Beethoven has been there.

They have a lot of different components, social work, medical. The residents that are a part of the Beethoven study have really taken hold of it.

It has brought to these six target buildings an overwhelming response, which I have never seen among my neighbors.

DR. HEIN: Do you think a large part of that was due to the outreach? That was an underlying purpose for it.

MS. ROBINSON: Yes, I think so.

DR. HEIN: A program without strong outreach is not as useful.

MS. ROBINSON: Yes, I really think so.

SENATOR CHILES: Mr. Ellis would like to comment.

MR. ELLIS: Just briefly, Doctor, I think outreach is a priority, but an additional component of the outreach is if your what if was a reality you have to have an outreach component that is indigenous--and I underscore that word--to the target population for the specific high-risk population group for which you are trying to bring access into the system.

To have a case manager who has credentials and certifications in their continuing-education unit who is not indigenous to that community and cannot understand the lifestyle and the background of the target population is pouring money down the drain, quite truthfully.

DR. HEIN: I'm sure that's true.

SENATOR CHILES: Dr. Sundwall.

DR. SUNDWALL: Mr. Chairman, I just wanted to follow up on that.

Because of the time limits, I didn't have an opportunity to brag about our Indian Health Service in the Public Health Service. I think the Commissioners are well aware that they have an extraordinary record of having lowered infant mortality over the last 30 years among that very difficult population regarding income and remoteness and education to a level that is now lower than the national average.

That is for Indians and Native Alaskans cared for in the Indian Health Service.

One of the reasons why it is so successful is because it is case-managed, primary preventive care, but also because they have just what we have been talking about, these indigenous case workers.

There is a community outreach program. I cannot remember the proper acronym, but they are really Indian people from the communities. They go into those homes.

They are culturally sensitive, as we have heard. They get them involved. It is not some fancy educated soul trying to tell them how to run their lives.

It is their own neighbors telling them that they would be better off if they would take advantage of this service or that.

I think we have hit on something that is really fundamental and has a good track record of being successful in these difficult target populations.

SENATOR CHILES: Would you and Dr. Roper take a cut at what Julius is interested in?

DR. ROPER: I believe he is interested in knowing how we get professionals to locate in under-served areas, and is interested in the National Health Service Corps.

I have a practical suggestion: we pay them more.

[Laughter]

In Medicare and Medicaid, we have built into our payment systems a bias against rural areas. That derives from the way the law was enacted in 1965.

I don't think that is appropriate. I think we ought to be paying a bonus for people who practice in medically-under-served areas. We would not need all the jazzy programs about discounting your loans and all of that business if you practice in an under-served areas if we just said, "We will pay you more if you practice in an area where we need a doctor."

Next year, Senator, you perhaps will not be there, but the Congress will get down to debating Medicare payment of doctors. That is one of the issues they are going to take on.

COMMISSIONER BOLTON: Mr. Chairman, I think he has hit right on the point. I think that incentive can get certain types of health care providers to work in under-served area, but I think also you have to apply the technology that's available here in America to fill other gaps.

You were speaking about laboratory results and all. I'm not bragging about our home-grown industry, but Federal Express has now combined with a major health care provider in our area to provide overnight laboratory services to anyone in the country that can be transmitted back to you electronically in the middle of the night.

For instance, if you get it to the airport by 5:00, by 2:00 or 3:00 in the morning you have your results over the wires.

There is technology for that. There is technology for other things that we can apply to these poor-people problems.

The barrier has simply been that we have been applying old solutions to problems that are growing and are becoming more complex and more demanding. We just have to step to the front of the line and apply these leading-edge technologies and add incentives to help solve the problems that are costing us more and more every year.

SENATOR CHILES: We are going to keep going for a few more minutes. I know that some of our audience are having to leave.

I want say that if you have information that you would like to give to the Commission, we invite you to write to our National Commission to Prevent Infant Mortality. We are at 330 C Street, Southwest, Room 2006, Washington, D. C. 20201.

If you don't remember that, if you will write to us through the Governor or through me we will still get the information.

We would be delighted to get any information from you all.

Congressman, do you have a question? We are delighted to have you with us.

The Honorable Charles A. Hayes, Member, U.S. House of Representatives.

CONGRESSMAN HAYES: I don't think I have a question. I represent a district that has a lot of problems in the area you are discussing.

I certainly want to commend you and the Governor, too, and members of this Commission for having the foresight to serve this kind of hearing.

It is my hope that this kind of exposure and revelation of the kind of problems you have been discussing will stimulate some real answers to the problems that are still in existence.

The distribution of health care to the poor community which my district reflects, at least in part, is on the decline. Infant mortality is on the rise.

I hope that we can find some more money, at least. Maybe it will mean that we will have to re-evaluate some of our priorities as to how we spend some of the tax money we get.

Certainly I am a firm believer in the old adage that if it's not broke, don't fix it. But it's broken now when it comes to the distribution of health care and we need to start fixing it.

I want to commend you for coming into Chicago. It is not just in the rural communities where we have a concern, it is in the urban areas.

The decline in health care, the rise in infant mortality prevalent particularly in the Black and Hispanic poor communities, in this whole country of ours.

Thank you very much for giving me an opportunity to appear here with you. I thank you for coming into the area in Robert Taylor homes and paying the visit you did this morning.

I hope it stimulates some activity in terms of dollars.

[Laughter]

SENATOR CHILES: Dr. Bowen.

SECRETARY BOWEN: I just have a couple of comments, one concerning the State of Florida.

It will be difficult to get obstetricians and family practitioners to deliver babies there until they get the malpractice insurance situation solved. The obstetrician's annual fee, I believe, is around $100,000 a year.

That takes the delivery of a lot of babies before you start to break even. We, in our Department, are trying to come to grips with that. I think you have taken a small step and I hope that will improve.

I have one other comment. I would like to see more emphasis on prevention of the problem rather than trying to solve it after it is here.

Don't misunderstand me, we need to solve the problems once the babies are here. For heavens sakes, let's take care of them and do it right.

But if one of the big causes of infant mortality is low birthweight and one of the big causes of low birthweight is teenage pregnancy, I think that we better tackle that problem.

The Federal Government alone and state governments, along with huge amounts of money, cannot solve that problem alone. We know that along with the correction of problems with housing and poverty and jobs and education and health we have to have a change of attitudes on smoking and use of alcohol and drugs and premature sexual activity.

There is no way that you can mandate these things. It is going to take the mothers and fathers and the grandparents and the teachers and the preachers and the community leaders of each community to get their own act together and try to change some of these attitudes.

I think Ms. Gaston said it very well in some of the comments that she made.

I would like to see a lot more emphasis on prevention. Our Federal Government, last year, spent $18 billion on teenage pregnancy alone. Think what you could do with that on some other needed programs.

SENATOR CHILES: We thank you for those comments.

We are going to start putting our Commission report together soon. We have one more meeting after this in which we will sit down and work on that.

This Commission goes out of being by the end of September. We are just a one-year Commission because we felt we did not have to further study the problem.

The problem is low birthweight. How do we address that problem? That is what we are trying to get this information together for.

SENATOR CHILES: Ms. Gaston?

MS. GASTON: Secretary Bowen, I am aware that you have a teen pregnancy prevention panel looking at those issues.

I am wondering if that organization has come up with any recommendations yet. Are you looking at things like comprehensive health services, cooperative efforts between school systems and local groups such as the St. Louis Junior League project?

How actively involved is Education in that effort?

SECRETARY BOWEN: I can assure you that they are looking at every possible angle. I have not received any final report on it yet, but I am looking forward to receiving it.

MR. BELL: Senator?

SENATOR CHILES: Yes, sir, Mr. Bell?

MR. BELL: I want to make two comments.

The first is on the notion of outreach that we talked about before in terms of what we do.

We have systems in this country now that can sell billions of McDonald's hamburgers to people and we ask health educators to compete with that, put together outreach pamphlets to try to reach high-risk clients.

Certainly the private industry technology is there and available to us to use if we are willing to grab onto that and utilize it. The "Just Say No" campaign is a good example of that.

It is everywhere. You cannot go anywhere without seeing something of that because it was a national commitment and it was done in a polished professional manner.

We have to stop looking at piecemeal approaches to this and look at more broad ones.

The second point, I just don't want the Commission to leave with the idea that if we wanted to we could serve all pregnant women and infants on the WIC program just by throwing some kind of switch. Two major things would have to happen under existing funding levels.

One would be we would have to stop serving children all together if we are going to use all that money for just the pregnant women and infants. The two years from now we would all be in front of the Commission on Childhood Malnutrition testifying as to why these kids are hungry.

Secondly, we would have to have huge economic transfers of money from states that are now serving children to other states that are not. That penalizes the states that were efficiently managed from the beginning and were able to maximize the resources they had available to them to the states that were slower to come along.

Like I said in my testimony, I think you have to look for a way of not taking money from one preventive program and shifting it around to prevent something else. In the long run you are not going to end up solving your problems.

You are just going to end up with a gap in the continuum and I hope that that is realized, that there is not a simple solution, particularly the WIC program.

SENATOR CHILES: Mr. Harris is here. He is the progenitor of the model that we looked at -- the Beethoven Project through the Harris Foundation.

It is such an interesting opportunity to see this combining of all of the services and doing this outreach that we have heard from Ms. Robinson and others. What kind of comments can you give us as we wrap up, Irv?

Irving Harris, Chairman, Harris Foundation, Chicago, Illinois.

MR. HARRIS: I am also quite convinced that, as was said earlier, prevention must be the key. I just want to talk about some other programs we have in Illinois that are funded by the Ounce of Prevention Fund, which is primarily funded by the state and also by other funds.

One of the programs in the Chicago Public Schools is working with middle school kids, kids in the sixth, seventh and eighth grades. We have been working now for four years in relatively small programs because there is not enough money to do them broadly.

We have been able to cut down the number of babies born to 11-, 12-, 13- and 14-year-olds. We ought to have more money for programs like that since nobody thinks it is a good idea for a 12-, 13- or 14-year-old girl to have her first baby.

The other program is 22 years old. We have been funding it, in part, for the last six years in the Ounce of Prevention Fund. It is called the Near North Help Program.

They started with nutrition and they have successfully built a certain amount of confidence on the part of the neighborhood so that they do now pay much more attention to nutrition.

They were able, in one little district, to cut the number of low birth weight babies from 44 to 14. That is a very, very important number.

We have to have many more community-based programs and they have to be funded.

SENATOR CHILES: Ms. Rosoff?

MS. ROSOFF: To go back to the question of outreach, I think the problem with outreach is not that we don't know how to do it. It is that we are afraid to do it because if we did it and it was successful, it would result in greatly increased costs.

The problem, I think, with all of the enlargement even of the Medicaid eligibility, I think the states have to realize that every time they put out a pamphlet, every time they have a public-interest message, it is going to cost them money. The more successful the outreach is, the more money it is going to cost.

Therefore, I think almost instinctively, programs protect themselves from the demands which might very well accrue from them if you give a party and everybody came.

[Laughter]

It would be a disaster for the budget of the states and the governors.

So, I think this is something that has to be faced realistically. Otherwise I think we can be very pious and make great and sentimental statements, but we are not going to get anywhere.

SENATOR CHILES: Bill, we let you start this off. We are going to let you finish it.

DR. ROPER: Maybe on the same theme because had I been giving you the testimony, I would have mentioned it.

I think that point about outreach and being scared of the costs is a very important one. It is one that is playing out in the Medicaid expansions and some other things that have happened in the last couple of years.

It is one in which I think the public health leadership responsibility in maternal and child health is critically important.

Those of us who are responsible through another channel and have a specific mandate for leadership outreach and education can safely go out and do things--make nuisances of ourselves, make loud noises, bring people in--and we don't have to answer to exactly the same budget analysts, at least.

There are ways in state and, I presume ultimately, federal Government in which the interplay of that activism versus the inevitable conservatism that goes with entitlement programs needs to be analyzed and stimulated.

SENATOR CHILES: I'm going to try to take just a couple more.

AUDIENCE COMMENT: I just want to comment briefly on Dr. Roper's testimony regarding the Medicaid program where he mentioned that Alabama is a participant.

We would not want to leave the impression that that is the case. The evidence around the country is that infant mortality rates among Medicaid-eligible people have decreased.

This really underscores the importance of those programs that are designed to serve in this area. They really are an important part of this.

Secondly, I would like to support three recommendations that have been made.

The first one is one about a national media blitz. What really needs to be created is a national conscience in this country that it is unconscionable for a pregnant woman not to receive adequate prenatal care.

That being the case, such a media blitz should demonstrate a commitment to adequate prenatal care.

SENATOR CHILES: I want to say that one of our hearings was held in California and we dealt with the media in Los Angeles. That is something that we are very much conscious of and trying to work on.

AUDIENCE COMMENT: Excellent.

In our programs in Michigan we find that while Medicaid has an infant mortality rate 2-1/2 times those who are not on Medicaid, those people on Medicaid who are under managed care have infant mortality rates at or below the average.

It is really important to take advantage of the opportunity to use managed care, care management, case management, whatever term they use.

Finally, the recommendation for an increase in access to care is well-founded.

[Applause]

SENATOR CHILES: Yes, ma'am?

AUDIENCE COMMENT: I heard someone say earlier that the person going for public aid should be told about WIC.

In most instances of the people that I know, when they go in for public aid nobody tells them about WIC. Nobody explains that WIC will supplement your food stamps, that this will help your food dollar.

Nobody tells them about Medichek, that these people will come to you and help you get to the clinic, get home or give you tokens, or however you want to do it.

If you don't explain to people what services are there, they don't know. If the services are there, why can the worker not just simply say not just, "sign this," "sign this," explain, "This will help your dollars and cents."

If you are talking dollars people will listen, especially when you are talking to poor people who don't have car fare to take their babies to the clinic or don't have help if they have six children.

I wish that all public aid would talk to people about what is available.

SENATOR CHILES: We thank you.

We thank all of you for your attendance. I want you to know that the Commission is dedicated to trying to make a difference here.

Governor, again we thank you for hosting us.

[At this time, the hearing was concluded.]

SUMMARY OF TESTIMONY
NATIONAL COMMISSION ON THE PREVENTION OF INFANT MORTALITY

By
Loren L. Bell, President
National Association of WIC Directors

Government must declare itself responsible for solving the problem of infant mortality. It can do so by taking a three-step approach:

1. Government can make better use of existing resources.

2. Government can redirect resources into more efficient areas.

3. Government can encourage and promote innovative approaches to solving problems.

First, government must view programs to prevent infant mortality as comprehensive, not categorical. To do so will better use existing resources available to us. Such items as having common eligibility determination systems as well as having common eligibility criteria would greatly increase the efficiency of providing services. In addition, governmental programs should provide financial incentives through funding formula and federal financial participation to make programs comprehensive and efficient.

Secondly, we can redirect resources to areas that promote prevention and early intervention. Declaring ourselves willing to fund prevention is the key. Most cost effective programs are in the realm of prevention. By redirecting funds to preventive programs in a predictable, consistent manner we can then better utilize resources that are currently being used in less effective areas.

Finally, we must provide incentives for innovative approaches to client services. Such things as WIC cost containment proposals, better use of the private sector, and increased use of media would help to more effectively use dollars in the prevention of infant mortality.

TESTIMONY

NATIONAL COMMISSION ON THE PREVENTION OF INFANT MORTALITY

Prepared by:
Loren Bell, President
National Association of WIC Directors
(WIC Director - State of Washington)

First, I would like to thank the commission for providing me the opportunity to testify today. It is a great priviledge for me to be able to share some of the views of the WIC community with regard to the critical problem of the prevention of infant mortality. I was interested to note in the material provided me by the commission that many of the solutions to preventing infant mortality already exist. We can learn lessons from other nations who have, over the last several years, passed us in terms of the prevention of infant mortality. I am here today to address some of the issues that we, as government administrators, must look at in order to resolve some of this problem.

First of all, government at all levels must declare itself responsible for solving the problem. We know how to reduce infant mortality. We have developed categorical programs that have had impacts on infant mortality. Yet the government at no point has ever declared itself responsible for reducing infant mortality. We must do that. Once declared, we then must take a three-pronged approach to deal with the problem. First, we must do the best with the resources we have. Second, we must redirect resources to solve the problem, and third, we can encourage innovative and creative approaches to resolving the problem. I'd like to examine each of these three areas.

First of all, we can do a better job with existing resources. Certainly we have devoted a number of resources over the years to prevention of infant mortality. Currently, there exists a large number of resources available to both public administrators and private agencies to deal with and solve infant mortality problems. Programs such as WIC, Family Planning, the MCH Block Grant, Medicaid, Food Stamps, all have had their impact and all of them are very important. Yet more often than not we view these programs as either categorical, in which case we focus the administration of these programs on a single purpose, or do them as block grants by which we ask those those closest to the problems to decide how to use the money. We rarely view these programs as part of a comprehensive system. That is the view that is necessary. The federal government must allow states to take categorical programs and view them as puzzle pieces that can be put together to form a comprehensive service delivery system to prevent infant mortality. In this manner a state can then transfer these programs to the local service level in a manner that protects the integrity of the program, but also allows them to deal with the individual client needs they face every day in their clinics. Failure to view programs as comprehensive is a major reason why today public administrators in WIC, Family Planning, MCH, Food Stamps, and Medicaid rarely ever talk to each other. They must view themselves as part of one system with common goals.

Yet, it is ironic that while we often refuse to view the entire system as interrelated, the best way to show just how interrelated programs are is to cut one of them. Congress and the administration must be aware that adjustments and cuts in one program often affect the whole system. A classic example of this is the WIC Program which Congress has generously been expanded over the last several years. Originally the WIC program was designed to be an adjunct to health care. Yet, with the growth of WIC from its inception to its current funding level, combined with the cutbacks in other domestic programs, including revenue sharing and the MCH block grant, as well as diminished local resources and tax bases, health care has almost become an adjunct to WIC. We need to make sure that when we make decisions about programs that we look at the whole picture and view the system as comprehensive.

The major government programs that serve to prevent infant mortality need to be encouraged to come together at the state level to attack the problem. Some steps have already been taken at the federal level to encourage this, but more are needed. Some examples of what can be done are:

1. Common eligibility determination where possible so that a client is made eligible for services to prevent infant mortality, not for individual programs. Clients often become discouraged over the myriad of eligibility requirements they must go through with every categorical program they are eligible for.

2. Common eligibility criteria where possible. An example of a "flaw in the system" is found in the WIC program under which federal regulation required counting a pregnant woman as a family of one, whereas Medicaid and Maternal and Child Health count that person as a family of two. Therefore, WIC is saying we will not pay for this woman to have good nutrition during the prenatal period, but when the infant is born unhealthy, we will take over and provide food for it.

3. There need to be financial incentives in both funding formula criteria and federal participation ratios for providing comprehensive services. By allowing the states to provide comprehensive services to individual clients through different categorical programs, such as utilizing Medicaid to pay for high risk nutrition care or special infant formulas that the WIC program might not normally provide, maximizes resources.

The second thing we must do to declare ourselves responsible for the problem is to redirect existing resources. The essential component of redirection of resources is making a commitment to prevention. We must declare that we will provide the necessary resources to prevent the conditions that continually cause increased cost and increased suffering among our clients. By starting with a planned pregnancy, adequate prenatal care and adequate nutrition during pregnancy, we can make major steps in preventing the high cost/low birthweight babies that are a product of inadequate services. Both prenatal care and WIC have been proven to be cost-effective. Yet, only 40 percent of those potentially eligible for WIC receive services now. Many, many women do not receive adequate prenatal care. If we found a cure for AIDS or cancer, would we only allow 40 percent of those needing access to the cure to have it available? Certainly not!

Governmental administrators often pride themselves on accomplishments, particularly in categorical programs. We set limited objectives for ourselves and we meet them. WIC, for example, over the last several years, has had a goal of trying to reach the highest risk clients. The federal funding formula was adjusted so states that see higher risk clients would be financially rewarded in doing so. The state of Washington has always served high risk clients. Currently, we rank third in the nation in terms of the percentage of clients that are high risk. Yet, every time we send a child to a home that could result in the child's death from child abuse or neglect, or every time we have to turn away someone because we only have money to provide funds to serve 30 percent of our potentially eligible clients, we are not doing our job and have no right to boast. The Washington State WIC Program, just last week, was required by the federal priority system to discontinue service to a young child, age three, who had leukemia. We did this because we did not have funds to continue this child on the program and there were pregnant women on the waiting list. So we are forced to make hard choices every week over children with handicapping conditions and children with high medical problems so we can put on pregnant women or high risk infants. These choices are hard to make and are really unnecessary. Resource redirection should be focused to serve all of those areas of prevention. What good is just preventing infant mortality if we condemn that child to a life of suffering and poverty.

Second, we must base our funding priorities on cost-effective outcomes. Most Americans want the deficit reduced and most Americans don't want to pay more taxes. In fact, many would rather see them reduced. Yet, we continually ask our citizens to pay for costly services that could have been prevented. This seems inexcusable. Prevention reduces deficits and reduces the burden to the taxpayer. We owe it as public administrators and elected officials to guarantee to the taxpaying public we are doing our best with their money. Protecting pregnant women and infants from unhealthy health outcomes is just as important as defending our nation.

Finally, with regard to reallocating resources, we must provide adequate, predictable funding for these programs. This means that we must set up plans for how we will reduce infant mortality, both in terms of the types of programs we will initiate, and how we will fund them and with how much money. We must set our targets so that we can plan well in advance. The constant fluctuation in funding and the unpredictability of regulatory changes often hamper states from accomplishing any kind of long-term stable funding to increase services.

The third step in our approach to declaring that we will solve this problem is innovative systems for delivering services. We must look at the most cost effective and creative ways of reaching our clients. WIC, MCH, Medicaid, and Family Planning have all taken some creative steps to address the issue. I would like to discuss a few:

1. In the WIC Program we have initiated infant formula cost containment programs to expand WIC caseload. This is a critical factor in being able to serve more clients within our existing resources. States

such as Tennessee, Oregon, Texas, Ohio and Vermont have taken great strides in this area and are leaders in the community in terms of infant formula cost containments.

2. The WIC Medicaid initiatives that Congress recently passed have also helped a great deal. These initiatives have started to contribute to an environment of getting together with Medicaid administrators and public health administrators to work in this common areas of concern.

3. The purchase of television time during highly watched programs and the development of commercials that would reach those clients who would not likely seek services. The old system of using public information spots on radio and television, particularly the ones at 11:30 at night, were not the most desirable to reach clients. Commercials during the Cosby Show paid for by the state to encourage pregnant women to seek prenatal care are far more effective.

4. Efforts to deal with teen pregnancies such as school-based clinics and making teen-agers aware of the responsibilities they will undertake in having a child at an early age.

5. Mobile prenatal care and WIC clinics that actually go out to where the people live and provide the services such as currently being done in the District of Columbia.

6. The use of private sector technology is very important. We must involve business and labor communities in this country in initiatives that will help prevent infant mortality. For example, the state of Oregon hired a marketing firm to determine what kinds of services brought people to clinics and what things discourage their participation. In Washington State we have developed our First Steps Campaign which uses the old political organization theory of community organization to make communities responsible for those in their communities who need to seek prenatal care.

7. Supermarket newsletters such as done in Maine and other states call attention to issues related to prenatal care to people who would normally pick those up for the shopper coupons.

8. We must make the public aware of the importance of solving this problem and what it means to them. Television programs, such as the recent "God Bless the Child" and "A Place At The Table," were a major step in doing this, but we must effectively utilize the social phenomena of television to make the public aware of what reduction of infant mortality really means.

9. We must develop role models and national spokesmanship for infant mortality prevention. We don't want people to see the unwed mothers who live such glamorous lives on the soap operas on late night television, but rather see the responsible people who have taken steps to try and prevent this type of tragedy from happening.

10. Finally, we all must take pride in what we do. Campaigns that were initiated from the grassroots of America, such as Bread For The World and Hands Across America, generate a lot of moving feelings among people. It is simple for us; we're talking about the life of a child--what could be more moving than that.

SUMMARY

OF THE

TESTIMONY OF JOHN W. BODE

ASSISTANT SECRETARY FOR FOOD AND CONSUMER SERVICES

U.S. DEPARTMENT OF AGRICULTURE

BEFORE THE

NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

APRIL 25, 1988

- An important part of the Federal Government's national effort to reduce the incidence of low birthweight by promoting an improved nutritional status of pregnant women is the Special Supplemental Food Program for Women, Infants, and Children (WIC).

- A host of interrelated factors affect birthweight and other measures of pregnancy outcome. These factors include nutritional status of the mother before and during pregnancy, maternal genetic or medical conditions, prenatal health care, and maternal behaviors such as smoking and alcohol or substance abuse.

- Currently WIC serves 72 percent of all pregnant women at the highest risk below poverty group and 88 percent of the infants in the highest risk below poverty group.

- Standing alone, however, the WIC program can not substitute for adequate prenatal care, but WIC program efforts to introduce participants into a health care network agument the availability of prenatal care.

- USDA, through the WIC program, has undertaken and implemented strategies to coordinate our efforts with Medicaid, the Maternal and Child Health Program, the Healthy Mothers, Healthy Babies Coalition, and other such groups at the Federal, regional, State, and local levels.

- At USDA, improved targeting of high risk participants is an ongoing program goal. USDA is currently conducting a study to assist State agencies in their targeting efforts.

- State WIC agencies have numerous initiatives underway to prevent infant mortality which range from expanded participant access to counseling on various risk factors to expanded services to pregnant teenagers.

- With respect to funding, WIC already receives enough funding to serve all of the pregnant women and infants with a medically based nutritional risk.
- Two other programs administered by USDA that assist in reducing low birthweight babies are the Commodity Supplemental Food Program and the Food Stamp Program.
- Only by working together can the tragic incidence of infant death be reduced.

TESTIMONY OF JOHN W. BODE

ASSISTANT SECRETARY FOR FOOD AND CONSUMER SERVICES
U.S. DEPARTMENT OF AGRICULTURE
BEFORE THE
NATIONAL COMMISSION TO PREVENT INFANT MORTALITY
APRIL 25, 1988

Mr. Chairman, members of the Commission, thank you for the invitation to appear today to discuss the U.S. Department of Agriculture's (USDA) role in reducing infant mortality. The issue of infant mortality is of deep concern to all Americans--a concern reflected by specific Federal programs designed to enhance the nutritional well-being of pregnant women, infants, and children.

The leading causes of infant mortality include congenital defects, sudden infant death syndrome, respiratory conditions, and prematurity and low birthweight. While anemia or other nutritional deficiencies are rarely indicated as primary causes of infant death, they may contribute to low birthweight.

An important part of the Federal Government's national effort to reduce the incidence of low birthweight by promoting an improved nutritional status of pregnant women is the Special Supplemental Food Program for Women, Infants, and Children (WIC). WIC serves as a supplemental feeding program and as an adjunct to prenatal health care for participating pregnant women. A host of interrelated factors affect birthweight and other measures of pregnancy outcome. These factors include nutritional status of the mother before and during pregnancy, maternal genetic or medical conditions, prenatal health care, and maternal behaviors such as smoking and alcohol or substance abuse.

Currently, WIC serves 72 percent of all pregnant women at the highest risk below poverty group. About 3.5 million low-income women, infants, and children are participating each month in the WIC Program. Our most recent data from 1985 show WIC serves two-fifths of all women, infants, and children eligible for the program based on the threshold criteria of income below 185 percent of poverty and a determination of "nutritional risk". Due to declines in poverty and recent WIC Program growth, the coverage rates are probably even better today. Approximately one in four American infants under one year old today is a WIC participant. In fact, 88 percent of infants in the highest risk below poverty group are served by WIC.

As you know, poor prenatal nutrition is one of the high risk factors affecting birthweight. The WIC Program provides low-income participants with supplemental foods and nutrition education which can positively affect maternal nutritional status and, in turn, positively affect birthweights.

The supplemental food packages provided by WIC are rich in the nutrients (protein, calcium, iron, and vitamins A and C), which are often found to be lacking in the diets of the target population. Nutrition education provided at WIC clinics teaches women about the importance of a good diet during pregnancy and often includes counseling on other risk factors, such as drinking alcohol and smoking, which adversely affect birth outcomes. As part of its management strategy, USDA, in conjunction with participating State agencies, has developed Nutrition Services Standards to enhance the quality of the nutrition education and counseling provided to participants at WIC clinics.

Standing alone, the WIC program can not substitute for adequate prenatal care. However, WIC Program efforts to introduce participants into a health care network through referral to and coordination with health care providers augment the availability of prenatal care. USDA, through the WIC Program, has undertaken and implemented strategies to coordinate our efforts with Medicaid, the Maternal and Child Health Program, the Healthy Mothers, Healthy Babies Coalition, and other such groups at the Federal, regional, State and local levels.

A priority system has been developed in the WIC Program to ensure that the highest risk eligibles are served first by the Program. Due to the link between prenatal nutrition and low birthweight, WIC includes high risk pregnant women in Priority I. Since high risk pregnant women are in the highest priority group, there should be few, if any, locations where they can not receive WIC benefits.

At USDA, improved targeting of Priority I participants is an ongoing program goal. WIC regulations have recently been changed to include a component in the funding formula that encourages increased State agency attention to targeting objectives. Additionally, USDA is conducting a study to assist State agencies in their targeting efforts. The WIC Benefit Targeting Study is a three year project to identify and field test strategies for targeting benefits to the highest risk pregnant women. Successful strategies derived from the study which can be adapted to local environments will be shared with State agencies.

USDA recently requested from the State WIC Agencies, information on their special efforts to prevent infant mortality. Initiatives underway (often through cooperative efforts with other agencies or programs) include:

- expanded participant access to counseling on various risk factors;

- enhanced targeting efforts to increase the caseload proportion of pregnant women and facilitate enrollment early in the pregnancy;
- extended services to pregnant teenagers;
- expanded referral networks; and
- efforts to create data bases that will allow an analysis of the effect of participation in the WIC Program on pregnancy outcome.

Specific examples of outstanding special initiatives to prevent and reduce infant mortality that WIC or local agencies organize or participate in include:

- Here, in Chicago, the Midwest Regional Office of the Food and Nutrition Service has joined with the Chicago Public Schools, the Illinois State Board of Education, and the Chicago Department of Health to organize the Chicago Pregnant Adolescent Nutrition Project. This project brought WIC clinic services into four alternative high schools for pregnant teens in Chicago and increased the amount of food in the school lunches to meet special nutritional needs of pregnant teenagers.
- In Rhode Island, the WIC Program coordinates with RITE Start, a program that provides maternity coverage for uninsured women at income levels up to 185 percent of poverty. An evaluation of WIC eligibility is standard procedure and guidelines call for the provision of WIC services or documented referrals. Eligibility determination is integrated if the applicant is WIC eligible.
- The WIC staff at the Colorado Department of Health have participated in a comprehensive Low Birth Weight Prevention Project. This project has been funded by the Department of Health and Human Services since 1983 to develop strategies for reducing the incidence of low birthweight. The objectives of the project were to reduce "behavioral" risk (i.e. smoking, alcohol use, poor weight gain) among publicly funded prenatal patients, and, thereby, to reduce the incidence of low birthweight. A program evaluation found that large proportions of women were able to eliminate behavioral risks of low birthweight.

- The Indiana WIC Program has undertaken a project aimed at increasing the birthweight of WIC infants. The project involves identifying high risk participants by risk factor, developing education plans and counseling techniques for each category of high risk participant, and implementing the education plans in WIC clinics. The project will be evaluated based on pregnancy outcome data.

- The GRADS Program is an in-school program offered through home economics departments in Ohio. The program attempts to improve teenage prenatal health practices and increase the number of pregnant teens who stay in school. WIC nutritionists often provide nutrition education for the GRADS Program; and all eligible teens are certified for the WIC Program.

- In California, a 3-year demonstration project by the Maternal and Child Health Program and the Adolescent/Family Life Program provides comprehensive case management of pregnant teens, including prenatal counseling through WIC. The program operates in 29 of California's 58 counties.

- The Kansas WIC staff cooperates with the State Prenatal Health Promotion and Risk Reduction Program, which is designed to reduce the incidence of poor pregnancy outcomes for Medicaid childbearing clients and their newborns.

- The Navajo Nation is currently working with the Indian Health Service's (IHS) Health Promotion and Disease Prevention Program to coordinate efforts to reduce low birthweight. WIC involvement includes: making presentations on nutrition for expectant Navajo mothers on Maternal Child Health Day of a conference cosponsored by the Navajo Nation and IHS; and development of a slide presentation on the importance of early prenatal care.

I have been asked many times if more funding for WIC would help to reduce infant mortality. My response is that WIC is already well targeted and serves a large proportion of the eligible low income pregnant women and infants. In fact, WIC already receives enough funding to serve all of the pregnant women and infants with a medically based nutritional risk.

An increase in WIC funding would probably go to serving children and others of the lower priority groups. Contrary to some views, WIC is no longer a small program. Since 1980, its funding has increased over 130 percent. WIC is well targeted and widely available to the population where it seems most effective.

Another program administered by the Food and Nutrition Service that is very similar to WIC is the Commodity Supplemental Food Program (CSFP). CSFP is also a grant program that provides commodity supplemental foods to low income infants, to children up to age six, and to pregnant, breastfeeding, and post-partum women. States unable to fill caseload with WIC may assist low-income individuals. CSFP also provides USDA donated commodities that are high in those nutrients usually lacking in the diets of the target population. To be income eligible for CSFP, applicants must be at an income level that would qualify them for Federal, State, or local food, health, or welfare programs for low income persons. Approximately 132,000 persons per month participate in CSFP.

For Fiscal Year 1989, the WIC Program and the CSFP are proposed by USDA to be combined in a single appropriation. Our goal is to allow States to better focus the funds to meet the needs of the highest priority groups. For example, in 1987, 4,074 CSFP caseload slots for WIC were converted to slots for lower priority low-income elderly. A combined appropriation would allow these WIC resources to provide services to the target group of WIC.

I would be remiss if I did not briefly mention the Food Stamp Program's role in assisting millions of Americans each month to supplement their food dollars. The Food Stamp Program is the cornerstone of domestic food assistance, accounting for nearly three out of every 5 food assistance dollars spent in Fiscal Year 1987. It provides a monthly benefit to anyone with low income and limited assets in the 50 States, the District of Columbia, Guam, and the Virgin Islands. It is very common for pregnant women or infants who qualify for participation in the Food Stamp Program to also qualify for participation in the WIC Program or CSFP.

Mr. Chairman, at present, USDA's array of food assistance programs are mature and adequately funded. They represent a major commitment on the part of the Unites States to prevent poverty-based hunger and to share in the efforts being made to reduce infant mortality. Clearly, we all have a stake in the health of our children, and USDA agrees with the Commission that, ".... everyone has a role in reducing infant mortality." Only by working together can the tragic incidence of infant death be reduced.

That concludes my remarks Mr. Chairman. I shall be happy to answer any questions.

PREPARED REMARKS OF SHELBY COUNTY, TENNESSEE
COMMISSIONER JULIAN T. BOLTON
BEFORE THE NATIONAL CONVENTION TO PREVENT INFANT MORTALITY
A HEARING AT THE STATE OF ILLINOIS CENTER
16TH FLOOR - 100 WEST RANDOLPH - CHICAGO ILLINOIS
APRIL 25, 1988

INTRODUCTION

Dear Members of the National Commission to Prevent Infant Mortality. I am very pleased to be here to have input on national policy relating to this very important issue concerning the future of children in America. I feel particularly qualified to speak on the efforts that we are initiating in Shelby County, which we hope will be a national model, because I represent the area where the infant mortality rate is the highest in our county. Furthermore, I have had a very close experience with my newborn child being close to death.

In 1981, my wife and I had this frightening experience with our second child, Jared, who was born at 26 weeks gestation and at a birthweight of 2.2 pounds. The doctor indicated that our child in all likelyhood would not live. After he was born and rushed to the neonatal care center, the neonatologist indicated as well that there was very little chance that our child would live. That began a very lengthy ordeal that my wife and I were required to endure. However, it provided me with a unique insight into the medical field and the business of hospital administration as it relates to low birth weight and high risk infants. I am very happy to say that my child did survive after six months in the hospital and after four months in the neonatology unit.

This experience was very costly in terms of dollars and the emotions that my wife and I were required to expend. I am convinced that had I not had the best type of medical coverage, which was provided by the Blue Cross/Blue Shield through my employment with the telephone company and had my wife not been a nurse at that hospital, we would not have a living child today. We were blessed, but, it made me think about the many millions of young mothers with high risk infants, who simply do not have knowledge of or access to the health care system. What is the fate of their young babies? If a hospital administrator had to decide whether the $125,000 that it cost for our child to be born was worth the risk, I think that he would have said no.

Many people in America simply don't have access to that kind of high quality, high technology health care. Those citizens are the people who need high technology the most because of neglect in other aspects of their lives. What we've discovered in Shelby County and what I'm discovering in reviewing the information that has been provided to me on infant mortality is that, those persons who need this kind of high technology and support the most, simply do not have it.

STATISTICS

Shelby County

POPULATION

The 1936 mid-year population of the Memphis and Shelby County community was estimated to be 812,000, an increase of 5,000 (0.6%) from the 1985 estimate of 807,000. The white population estimate was 440,000 (54.2%), and the nonwhite population was 372,000 (45.8%). The mid-year estimates for 1987 are white - 441,000 (53.9%), nonwhite - 377,000 (46.1%), total - 818,000. The 1986 City of Memphis population was estimated to be white - 287,000 (45.4%), nonwhite - 345,000 (54.6%), and total - 632,000.

LIVE BIRTHS

A Total of 13,911 resident live births was recorded in 1986, a slight decline from the 14,003 recorded in 1985. The birth rate also dropped from 17.4 births per 1,000 population in 1985 to 17.1 in 1986. For the 15th consecutive year, nonwhite births (7,763) out-numbered white births (6,148). The nonwhite births represented an increase from 1985; white births decreased in 1986. The white birth rate was 14.0, and the nonwhite rate was 20.9 in 1986. A Total of 17,370 live births were recorded in 1986 including non-resident figures.

ILLEGITIMACY

New records were set in all categories of illegitimacy in 1986, breaking all of the previous records set in 1985. A record total of 5,761 illegitimate births was recorded for residents of Memphis and Shelby County in 1986, also establishing a new record percent of 41.4%. The white figures (562, 9.1%) and the nonwhite figures (5,199, 67.0%) were all new record highs.

PREMATURITY

Prematurity figures were down slightly in all categories in 1986 (Premature = baby weighs less than 5.5 lbs at birth). The number of premature babies was whites - 324, nonwhites - 923, TOTAL - 1,274; the prematurity percents were white - 5.3%, nonwhite - 11.9%, Total - 9.0%.

TEENAGE PREGNANCY

The number of teenage pregnancies dropped slightly from 2,360 in 1985 to 2,354 in 1986, a decline of 6. The primary teenage "population at risk" - females age 15-19 - had a fertility rate of 7.0 (births per 100 females age 15-19) based upon 2.245 babies being born in 1986 to the estimated 32,000 females in the age group. In other words, 7.0% of this age group had babies in 1986. This group also had a record 80.8% illegitimacy figure in 1986, and 25.3% had had previous children. This age group also had 1,354 abortions (4.2%) according to provisional state data. In summary, over 11% of the females in the 15-19 age group either had a baby or an abortion in 1986.

INFANT MORTALITY

A total of 195 infant deaths occurred to Memphis and Shelby County residents in 1986, resulting in an infant mortality rate of 14.0 infant deaths (under 1 year of age) per 1,000 live births, the second lowest figure on record, topped only by the 13.1 figure set in 1984. The white infant mortality rate was 8.3. The nonwhite infant mortality rate was a record low (18.5) topping the previous record of 18.6 set in 1984.

Key Factors

- Very low birthweight infants account for a highly disproportionate amount of infant deaths
- A disproportionate number of high risk infants are born to teenagers
- A disproportionate number of Black teenagers become pregnant and give birth

- A significant number of teenagers will experience a second pregnancy within one year
- Short intervals between pregnancies (less than two years) increase the risk of having a low birthweight infant
- Black women and adolescents are the least likely to receive adequate prenatal care
- Pre-existing or intrapartum medical disorders are associated with an increased incidence of low birthweight and infant mortality

SPECIAL PROJECTS IN MEMPHIS/SHELBY COUNTY TO REDUCE INFANT MORTALITY

The Health Department implemented a special project to provide education and counseling for pregnant women who previously had a very low birthweight infant in April, 1987. These women are identified at Gailor OB Clinic and referred to a Health Department nurse for counseling and education in the woman's home. The nurse also helps the women/families with other problems, e.g., utilities, housing, emergency food, transportation, etc. So far, eleven (11) women have delivered full term healthy babies, and five (5) women have delivered premature (weighing less than five and one half pounds) healthy infants. Three (3) women lost their baby due to medical complications. Currently, there are twenty-seven (27) women enrolled in the program.

Another special project (funded by the State) begin in 1987, and targeted six census tracts with long histories of high infant mortality. Lay home visitors are going house to house throughout the census tracts to identify women who are pregnant. The importance of early and continuous prenatal care is stressed. Referrals are made for health problems of all family members. Classes are held in the community on the importance of prenatal care, spacing of children, child health and parenting skills for new mothers. This project has found ten (10) pregnant women who were not receiving care, two (2) women who were not keeping appointments, three (3) high risk women who were referred to a nurse for additional education/counseling, ninety-two (92) children needing immunizations and check-ups, twenty-nine (29) adults needing assistance for social problems or medical conditions, and thirty-nine (39) women and teenagers in need of family planning information (including abstinence). There is an active caseload of eighty (80) pregnant women. To date, only one woman has delivered an infant weighing less than five pounds.

The Health Department placed a nurse in the Alternative School for Pregnant Girls this school year to provide education and counseling for the girls, as well as family members in the home. As the school year progressed, the number of girls having premature or low birthweight infants has decreased.

OTHER ACTIVITIES

Health Department nurses are following pregnant teenagers and women at high medical risk in the homes to provide education and counseling. These same nurses also are following infants at risk for medical and social problems. The nurse's case loads are over 300 families per nurse. These families do not get the individual attention as the special project families, due to the heavy volume being followed by the nurses.

The Health Department also provides prenatal care and educational classes to pregnant women at low risk in nine clinics. These women receive their original work-up at The MED and are referred to their neighborhood clinic for care. The women deliver at The MED.

A) Develop a plan to efficiently transfer funds from and between health institutions as demand for services requires.

B) Diversify services offered by the primary health care clinics by creating, expanding, or enhancing, or improving referrals to public health services now offered.

C) Continue an analysis of the operations and programs of The MED, the Memphis and Shelby County Health Department, Oakville Health Care Center, and the Shelby County Health Care Center to implement organizational and operational changes needed to better coordinate services to the poor. These efforts should focus on home and community based care as an alternative to institutional care, a review of the appointment scheduling and pre-admission screening process, and the coordination of better service for clients who use a broad range of health services.

D) A coalition within the health care system should be developed to promote and sponsor health fairs and self-help progrmas for the poor, to market available programs, and to involve community-based organizations in planning health-related programs and projects within the culture of poverty.

E) Develop a joint plan between agencies to focus on health programs in the schools, particularly related to drug and alcohol abuse, teenage pregnancy, immunization, stress leading to suicide, AIDS and other sexually transmitted diseases.

F) Develop a program to encourage and promote personal responsibility and knowledge of how to acquire adequate health care by poor families.

G) Initiate a neighborhood-based health research program to identify long-range health problems. Such research could lead to reduction in the causes of illness and result in a reduction in future treatment expenses. Expand the existing Health Department neighborhood based health outreach/education program to identify both short-range and long-range health problems. This should be accomplished by expanding the number of district health nurses available to work one-on-one with citizens in their assigned census tracts. The district nurses could and should be assisted by volunteer lay health workers or by health aids assigned to and in the Health Department budget. This will enhance the "case manager' concept and will provide for a professional person to be the citizens' contact, and a person who will be knowledgeable of the individual needs. Through education and referral, as appropriate, this district nurse can effect a positive change in a large number of indigent persons' lifestyles and health status.

H) Develop networks with appropriate community health centers to meet the special needs of mental health care and health care of the elderly, disabled poor and street people.

I) Develop new indigent health care service initiatives and cooperative programs between the county-funded public health care system and the private physicians and health care institutions in Shelby County.

J) The poor must have all health services available to them that are available to the non-poor.

K) Expand in-school health education programs utilizing health professionals in all schools.

The Health Department clinics have a long history of the majority of the women delivering full term infants (less than eight percent deliver early).

The Health Department also provides pregnancy testing and counseling at nine clinics. Every effort is made to assist pregnant women to apply for Medicaid and supplemental food programs, and to enroll in prenatal care.

FREE THE CHILDREN

In addition to the specific projects that I have mentioned just previously relating to the infant mortality situation in Memphis and Shelby County, Shelby County Government has initiated a very progressive and affirmative program entitled "Free the Children, Breaking the Cycle of Poverty". We feel that this program, if implemented fully, will deal with the root causes that result in the symptoms of high infant mortality rates, low standards of living, and a lack of promise in the lives of many of the citizens in our community. The health care issues are just a portion of the wholistic approach that we are taking in Shelby County to demonstrate to the nation how to move families out of the cycle of poverty which causes circumstances that lead to poor health care, poor health in general, as well as infant mortality. We found that responsive and affordable health care simply is not sufficiently accessible to the poor. Various factors were responsible for this grave situation, the most prevalent of which is high cost. Additionally,

1) lack of insurance
2) limited transportation
3) difficulty in obtaining appointments
4) lack of knowledge about health programs
5) a discontinuity in patient care and case management, and
6) a total absence of certain highly needed services

All these contribute to the cycle of poverty which leads to poor health care and high infant mortality rates, particularly among poor Black citizens.

The philosophy of Free the Children is simple. It should require parents in poverty to take responsibility for their families, even unborn children. And it provides them with the means to do so --- **work**, in community daycare centers --- **work**, in the rehabilitation of homes, including their own --- **work**, revitalizing their own communities --- **work**. At the same time we encourage them to recognize their individual strengths and the support systems available to help them through the transition between welfare and **work**.

Presently Shelby County Government is involved in efforts to implement the Culture of Poverty program recommendations in a target area which has been previously identified as a high impact area. The following executive summary describes the implementation procedures which are now being operationalized in the selected target area. The target area is in the north central portion of the Memphis community. It is a typical deteriorating community with a long history of poverty and neglect.

EXECUTIVE SUMMARY

The following report outlines the current status of our efforts to implement the Culture of Poverty recommendations. The report is organized in sections covering:

I. General Administration
II. Programs
III. Church & Community Relations
IV. Communications

Based upon our efforts and observations, we recommend the following:

1) Adoption of the housing program and finance recommendations, and preparation of programmatic regulations for implementation prior to July 1. (May 1 target date);

2) Endorsement of the census administration team proposal;

3) Appoint sponsors Board;

4) Approve development of internal "Brain Trust"; Create a Chair of Excellence in Government for the purpose of looking at new education model with interns from target area, universities and school system; emphasis on policy development for the Culture of Poverty;

5) Adopt staffing proposal, and delegate appropriate administrative authority to the lab;

6) Authorize development of service delivery roundtable from agencies involved in program development;

7) Authorize development of donation place through United Way Venture Fund;

8) Authorize development of a volunteer program.

9) Authorize Speakers Bureaus, and communication recommendations.

10) Authorize $3,000,000 appropriation in county budget including discretionary funds for programs in support of the initiative.

I. General Administration

In order to facilitate the implementation, the office of Community and Family Initiatives (CFI) is being established to insure proper planning, evaluation and reporting for the "Free the Children" Initiative. The CFI office will be temporarily located in Room 402 at 157 Poplar. This office should be ready for occupancy within two weeks.

Staff for the office will consist of four persons: an administrator, a planner/evaluation specialist, a program specialist and a secretary. A temporary planner has been hired to work with neighborhood groups and service providers to insure overall coordination of the effort. Specifically, the planner is organizing meetings with area leaders and assisting in implementation of the area wide census.

The plans for use of 918 Breedlove have been finalized (see floor plan). The acquisition and renovation of the property has taken longer than planned. The closing of the property is now in the hands of the closing attorney, Mr. Charles Perkins. At this point, Mr. Perkins is awaiting the title information before a closing date can be set. In addition, the arrangements to renovate the property have not been finalized. With this in mind, planned open house on March 22 should be set as a separate event from the announcement of the target area. We could announce the open house on March 22.

Planning for the March 22 announcement is on schedule. The auditorium at Northside High School has been confirmed. A proposed agenda and a list of guests is attached. The logistics of the event are being worked out. Where possible we plan to use Northside's facilities and students.

The program planning phase is to be completed by April 15. At that time, we will publish a comprehensive plan for the area.

II. Program Development

1) Housing & Economic Development

A) Community Service Center: 918 Breedlove

NHED office revenue to provide for acquisition of this FHA forclosure. Housing staff prepared rehab specifications and will provide construction support to lab.

B) Housing Finance Package:

Finance package includes $5 million bond proceeds and $1.1 million excess revenue from 1980 Series A mortgage repayments. This $6.1 million package provides for 100 acquisition loans, 100 rehab loans, a construction loan pool, property management program, homeless shelter operations, innovative energy conservation program, and support for the establishment of a modular housing plant at the penal farm.

C) Economic Development:

Construction loan pool included in housing finance package to assist small/minority firms.

Working to prepare TEDC application for business support.

Working with MSU on legislation to support inner-city agricultural co-ops.

Business survey will be designed and completed to match area business opportunities to the wider market place and to identify potential employers.

D) Code Enforcement:

Met with HCD and Codes Department. Codes is completing commercial inspections first.

Residential will be instituted next.

Enforcement procedures will then be undertaken.

A review and analysis of the code and enforcement procedure will be started after the commercial inspections are completed.

E) State Housing Legislation:

Continue to work on Governor's Housing Task Force and monitoring housing bill. Met with Lt. Governor Wilder to secure needed amendments. Potential $2 to $3 million housing support anticipated via bill.

F) THDA Reservation:

Designed reservation mechanisms to secure additional $1 million for housing development through THDA reservation process.

G) Housing Waiver:

Primary housing waiver requests have been identified.

H) Pension Fund:

Working with FHA to design proposal for pension funds to support housing redevelopment. County pension fund proposal can serve as challenge to all other area pension funds.

I) United Way:

Working with United Way to prepare $200,000 application for national demonstration program to prepare community based organizations to interact in the housing industry.

J) Chamber of Commerce:

Kicked off Chamber Housing Trust Fund activity February 22 to generate capital financing for low-income housing development.

K) MHA Housing Demonstration:

Working with MHA to start construction at Kansas Street Development site.

L) Housing finance resolution being prepared to generate funding through permit surcharge and property sales.

2) Homeless Shelters/Service Coordination

Shelby County NHED secured $250,000 grant from DHS to renovate 19 unit apartment complex as emergency shelter for families.

FHA multi-family office in Nashville is providing free appraisal to meet condition of grant award.

MLGW/TVA is providing 25,000, 0% interest loan to support rehab and energy standards. Also supports match requirements.

It is proposed that MHA contacts with Shelby County Government to manage the McLemore site. In addition, CSA will provide for social and medical services to homeless individuals housed at the facility. The homeless program(s) in support of the initiative can be supported at this site.

3) Child Care

Presently, all children who live in the target and who are enrolled in Community Day Care and Head Start programs are being identified. In addition, a survey of child care facilities in the area is being conducted and will be completed shortly. This survey will help us to determine need for addition child care slots and also detail the capacities which these centers have to add more children at their present sites.

Agencies Involved

Community Day Care & Comprehensive Social Services
Associated Catholic Charities
Porter-Leath
CSA Head Start Program

4) Youth

A preliminary meeting has been held with youth service providers to develop a coordinated youth program. The program will be designed to address a continum of needs for youths ages 6 to 14 and employment, training, and support services needs for youths between ages 15 to 18.

5) Education

Memphis City Schools is taking the lead on developing the education component. Ms. Sarah Lewis will have a proposed plan within the next two weeks which will be reviewed by a committee which is being formed now. The proposed plan will be coordinated and integrated with the plans being developed by the Youth Committee.

6) Legal

Mr. A.C. Wharton has developed plans for a legal services component which includes: 1) services to small business; 2)legal barriers to employment; 3) creating a process to expedite cases within the target area; 4) a "legal checkup" system designed to prevent future legal problems; 5)police-community relations; 6) community legal education; 7) a community legal ombudsman; and 8) provisions for an area legal advisory committee. Mr. Wharton is presently organizing a planning team to finalize these ideas.

7) Health Care

Mr. Dick Swiggart of the Health Department is responsible for planning the health component.

Presently, the plans include the expansion of the district nursing outreach services, expansion of clinic operations, training lay health workers (UT is looking at developing a certification program), night hours at the Jefferson pediatric clinic and developing environmental health services for the area. Most of the health services are designed to benefit the entire population of the target area. Special emphasis will be placed on the 125 targeted families through concentrated environmental issues associated with individual dwelling units.

Agencies Involved

Memphis & Shelby County Health Department
Medical Society
University of Tennessee
The MED

Mental Health

Darrell Jean is developing the mental health services component. He feels that the mental health services, including an alcohol and day program for the 125 families can be provided by his office, with follow-up services being provided through the mental health network.

Agencies Involved

Shelby County Employee Assistance Program
Midtown Mental Health Center
Alcohol & Drug Council
Memphis Mental Health Institute

8) Transportation

Presently, transportation networks in the target area are being identified and mapped. The MATA routes in the area have already been mapped. In addition, analysis of car ownership, car/van pools, MIFA transit system, MATA Handi-Lift operations and use of taxi cabs in the area. When finished this analysis will provide a basis for planning transportation for the target area.

Agencies Involved

OPD
CSA
MATA
MIFA

9) Employee Involvement/Participation

A) To increase awareness and involvement of Shelby County employees in this initiative, we are working to develop a system of employee participation in community events.

This project will be modeled after the neighborhood liaison program of Louisville, Kentucky. In this system, employees volunteer to participate in target area projects. Volunteers are trained on neighborhood interaction and assigned specific tasks. Often employees can be assigned within their own neighborhoods.

This facilitates two way communication between community organizations and the county.

Facilitators report their actions to a central point, in this case, the Culture of Poverty lab, and are paid with comp time for their work.

B) Shelby County Employee Residency Survey

The Personnel Department is completing research to identify the number of Shelby County employees that live in the target area. This information will assist in designing the neighborhood facilitation program and the pension fund investment proposal.

These employees can serve as valuable communication links within the area.

C) Pension Fund Investment Proposal

We are designing a proposal to present to Jim Campbell with the pension board to provide for making Title I rehab loans for county employees and retirees at an 8 to 10% interest range.

Will meet with Phil Shultee, Title I administration with HUD during the NaCO meetings on March 7.

10) Census Administration

The proposal, work plan, and budget for the census project has been completed and will be presented to the United Way Venture fund on March 9.

The proposal creates a census team consisting of Shelby County, City of Memphis, United Way, Federal Express High Tech Team, UT, MSU, and LeMoyne Owen College.

The budget reflects participation of each member of the team.

A key to the project will be to hire area residents to conduct the survey under the management of MSU and LeMoyne. Data will be analyzed by UT and Federal Express.

The involvement of UT will lead to the development of a "Lay Health Worker" curriculum to support the involvement of area residents in health maintenance and will assist in creating a new health profession in the Memphis area. It is our understanding that no other university in America has such a certification program.

OFFICE OF COMMUNITY & FAMILY INITIATIVES

Fiscal Year 1988 Budget
(March 1, 1988 - June 30, 1988)

SALARIES	
Administrator ($3,343/month)	$13,372
Planner-C ($1,544/month)	$ 6,176
Program Specialist-D ($1,272/month)	$ 5,088
Program Specialist ($1,213/month)	$ 4,852
TOTAL SALARIES	$29,488
Fringe (27.5%)	$ 8,109
TOTAL SALARIES & FRINGE	$37,597
OPERATION AND MAINTENANCE	
Travel	$ 2,500
Local	(500)
Out-of-town (4)	(2,000)
Communications	$12,700
Phones (3)	(200)
Long Distance	(250)
Printing	(10,000)
Postage	(2,200)
Subscription, Publications	(50)
Supplies	$ 7,200
Desks (4)	(2,000)
Paper, Pens, etc.	(200)
File Cabinets (3)	(600)
Chairs (6)	(900)
Micro Computer/Word Processor (2)	(3,500)
TOTAL O & M	$22,400
TOTAL BUDGET	$59,997

III. Church & Community Relations

Many groups and churches have expressed an interest and a willingness to support the "Free the Children" Initiative. These groups have primarily been interested in learning more about the initiative and volunteering time and money in support of the project. In addition to local groups interest there have also been out-of-town groups who are interested in tracking the project.

To a large extent this interest is predicated on the publicity we have been able to generate for the initiative. To date, we have appeared before a number of groups explaining the initiative. We must develop a regular report to interested groups to keep them updated, as well as explaining how they can be involved. To accomplish our need to communicate with the community, we should take the following steps:

1) Develop a quarterly newsletter to update the community on the initiative and to share other information related to poverty programs;

2) Develop a core of volunteers and decide how and in what activities volunteers can be used;

3) Develop a mechanism to receive donations to support the initiative; the United Way Venture Fund could be used for this purpose;

4) Develop a presentation which can be taken to interested groups; the presentation should be updated/revised every three months;

5) Develop a speakers' bureau to make the presentation.

In addition to relationships with groups outside of the area, the churches in the area are being contacted in preparation for a meeting the week of March 7, 1988 to gain their support for the initiative.

Presentations Made to the Following Groups

Tennessee Association of Community Action Agencies
Tennessee Conference On Social Welfare - Local Public
    Policy Committee (Support resolution passed)
St. John's Presbyterian
Grace - St. Luke's Episcopal
Office of Business Research (MSU)
MLGW
TVA Energy Conservation Office
National Association of Social Workers - Local Chapter
Shady Grove Presbyterian
First "
Advent "
Buntyn "
Greenwood CME Church
Catholic Diocese

IV. Communications

A) Streamline Internal Management Communications:

In order to facilitate communication and a common framework for decision making and a consistant understanding on the projects status we recommend bi-weekly meetings with the Mayor regarding policy direction.

B) Employee Communication:

To foster employee understanding and involvement in the project, we recommend institution of a county employee facilitation program, and frequent notices from the mayor's office to all departments concerning status.

C) Interagency Communication:

The key to overcoming interagency turfism will be to manage all information and communication carefully and for the purpose of generating action.

This interagency communication should focus on a block of 5 to 7 major contact points. Too scattered a focus will dilute our efforts and will result in more and more unsolicited proposals.

D) Community Wide Communications/Marketing

Public awareness, opinion, and support will depend largely on our efforts to manage community wide communications.

To saturate the community, we are planning a 3 pronged approach to include 1) development of a standard informational presentation and training for presentors (neighborhood facilitators), 2) a set of concise, targeted brochures that describe the program and promote participation/volunteerism/contributions, etc. for various populations. 3) And an organized media campaign.

Sonia Walker with WHBQ is interested in putting together such a program.

Our recommendation will be to develop an 8 part series, 30 minutes, covering general description and history of the Think Tank work, each of the recommendation subject areas and a conclusion tape.

From this series we could then edit specialized tapes as needed or use topic tapes for certain presentations as needed.

CASE MANAGEMENT FLOW CHART

INTAKE

1. Any interested person in target area can sign up.
2. Give handout and informational packets.

SELECTION

1. Participants selected based on criteria and first come.
2. Lab & case management staff supervise selection.

NOTIFICATION

1. Letters to participants setting up appointment.
2. Letters to persons not selected, explaining process & area-wide programs they can be involved in; explain timetable for additonal families to be involved in initiative.

ASSESSMENT

1. Client & Counselor to fill out assessment forms to determine service needs.
2. Analysis of service needs for family.

CONTRACTS

1. Counselor discusses contract with client insuring that all services are provided for.
2. Counselor and client signs contract.
3. Total service needs for all families.

SERVICE PROVISION

1. Counselor arranges for services such as day care, trans. after school & educ. job training, etc. for meeting individualized goals.
2. Client begins to interact with service providers with directions from counselor.

COUNSELING

1. Counselor counsels family on progress/problems and seeks to correct.
2. Counselor interacts with service providers to monitor progress.

JOB REFERRAL & PLACEMENT

1. Counselor arranges for job referral & placement.
2. Provides further assistance as needed.

FAMILY EVALUATION

1. Counselor evaluates family progress monthly for 1st three months.
2. Adjust service provision as needed.
3. Follow-up with service providers & assess providers delivery of service.

BEST COPY AVAILABLE

REMARKS BY

OTIS R. BOWEN, M.D.

SECRETARY OF HEALTH AND HUMAN SERVICES

BEFORE THE

NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

APRIL 25, 1988

CHICAGO, ILLINOIS

I welcome the opportunity to discuss with you what the Federal Government is doing to address the problem of infant mortality.

It's always nice to begin with good news. I'm happy to report that our latest provisional data, reflecting the period from January to October 1987, show that the steady decline in the rate of our infant mortality has resumed.

As you know, that decline, which began some 30 years ago, showed signs of slowing down in 1985. Apparently the efforts of all of us paid off, however, because two years later the downward trend was clearly reestablished.

There are still pockets of resistance, so to speak. The rate of black infant mortality is still twice that of whites and remains high in places like Indianapolis and Washington, D.C.

In addition, there doesn't appear to be any change in the incidence of low birthweight; there is even a slight increase in the percentage of very low birthweight infants. And there has been no improvement in the percentages of women receiving no prenatal care or in those entering care in the first trimester.

Despite some good news, our work is still cut out for us.

On the Federal level, where the responsibility resides in the Department of Health and Human Services, we are waging the campaign on a number of different fronts:

-- We are conducting or sponsoring basic research into the causes of low birthweight and prematurity;

-- We are applying research with programs to reduce cigarette smoking, alcohol and drugs and poor nutrition during pregnancy and to prevent teenage pregnancy;

-- We are conducting epidemiologic surveillance, tracking the prevalence of poor outcomes nationwide, in the states and in local communities and monitoring progress in improving these outcomes.

-- And we are attempting to ensure access to services for the un-served and the under-served by providing both medical care coverage and prenatal coverage to the poor.

A real obstacle to providing greater access to prenatal care is the specter of malpractice liability which is restricting both the number and availability of obstetricians.

Last August, a special Department commission issued a report on the general problem of medical liability. That was followed by proposed model legislation for the states to adopt.

We will soon support a symposium to be held by the Institute of Medicine on the effects of liability on the delivery of maternal and child health care.

Almost all of our infant mortality efforts are concentrated in two components of the Department of Health and Human Services. They are the National Institute of Child Health and Human Development and the Bureau of Maternal and Child Health and Resources Development.

Within this framework, we formed in 1984 a Low Birthweight Prevention Work Group which serves as the focus and coordinator of our efforts to develop an organized, sustained and responsive approach to the problem by identifying policy issues and implementing special initiatives.

We work closely with states, local communities, the health professions and the private sector to target and reach areas or populations with the most pressing maternal and infant health needs.

The chief vehicle of our cooperation is the Maternal and Child Health block grant program which provides formula-based allocations to states to support a broad range of services, including preventive, primary care and habilitative support for mothers and children.

Within a great deal of state flexibility built into the program, the primary emphasis nationwide is the integration of Federal, state, local and private efforts. This kind of collaboration encourages communication, keeping Federal priorities targeted in the needed areas, and enables talents and resources to be used efficiently.

Even though the effort is comprehensive, there is always room for improvement. We are, indeed, open to suggestion.

Directing the Federal effort as Secretary of Health and Human Services and serving on this commission, I am more than willing to be a catalyst in both directions. The problem is only going to yield to the concerted force of the best in all of us.

I look forward to today's discussions.

Thank you.

####

Senator **Lawton Chiles**

Florida

Senate Budget Committee, Room 621 Dirksen, Washington, D.C. 20510 202-224-8695

CONTACT: Rick Farrell

IMMEDIATE RELEASE
April 25, 1988

Remarks of

Senator Lawton Chiles

at a Hearing on
The Role of the Federal and State Government
in Reducing Infant Mortality

Chicago, Illinois
April 25, 1988

I want to begin this afternoon by offering my thanks for the hospitality that's been extended our commission members. We're certainly grateful to be here among these distinguished witnesses and guests.

Congress created the National Commission to Prevent Infant Mortality because we believe that the health of the nation starts with the healthy birth of a child.

This hearing reaffirms that belief. Our aim today is to explore what we can be done to improve the health of a child from the very beginning of life.

This isn't our first hearing. Already, we've looked into what the private sector can do. We've been to Los Angeles to see what the media can contribute to an overall awareness of children's issues.

Now we want to examine what government can do.

The fact that this commission exists at all provides some evidence. Our experience so far tells us people are willing to respond. Many are willing to contribute their time and expertise. Others have been receptive to the need to dramatize the problem of infant mortality.

Our role on the commission up to this point has been to help frame the problem and mobilize support in pursuit of a solution. But I think government can do more than that.

It's a hard truth of our times that money is limited by deficits both home and abroad. It's limited further by the competing demands.

So it seems to me we have an obligation to help financially where we can. But since our dollars are limited, we have to avoid duplication and confusion.

We will hear today from a quality cross-section of people in state, local and the federal government. I hope the discussion will focus in on practical approaches. We need to find ways to integrate maternal and child health programs at all levels of government so that those in need are not overlooked.

We'll begin with opening statements from our first series of witness, followed by a discussion, then the presentation of our second panel.

Let me encourage all of you -- Commissioners and witnesses alike -- to speak your minds and ask questions.

If we're lucky today, we may touch the vitality and imagination among our guests that can lead to still more ideas.

Let me now call on Governor Jim Thompson to lead off. And as I do so, let me offer my thanks for the kindness and concern you've shown us on our trip.

Governor.

Congressman Richard J. Durbin
U.S. House of Representatives

SUMMARY STATEMENT
National Commission to Prevent Infant Mortality

The State of Illinois is among the ten states with the highest infant mortality rates in the country. Statistics show that to meet the U.S. Surgeon General's infant mortality reduction goal for Illinois, we will have to triple our present rate of progress. While there have been many innovative programs instituted in Illinois and in other states that are designed to stress the importance of good prenatal care, there remain some serious gaps in care.

Last October, the U.S. House of Representatives Select Committee on Children, Youth and Families held two hearings in Illinois on the issues of infant mortality and access to prenatal care. I requested the hearings as a means of bringing the medical community and government officials together in order to begin focusing on the factors that are causing our State's high infant mortality rate. The hearings focused on the importance of prenatal care and on the difficulty that some low-income pregnant women have in securing the care that they need.

I believe that simple information about the necessity of adequate prenatal care, and where to get affordable care, is an important first step toward reducing the infant mortality rate. Recently I distributed a pamphlet to residents in the 20th Congressional District that stressed the importance of prenatal care and included a toll-free, state-sponsored hotline referral number where women can call for information on nearby facilities offering affordable prenatal care. The pamphlet was compiled with the assistance of the Illinois Department of Public Health, the March of Dimes, and Southern Illinois University School of Medicine.

Members of the Illinois Congressional Delegation have also joined me in spreading the word about the importance of continuous and adequate prenatal care by sending the prenatal care pamphlet to their districts across the State. We have also produced numerous public service spots stressing the importance of prenatal care.

Early and continuous prenatal care is a cost-effective way to reduce infant death rates. The estimated cost of delivering comprehensive prenatal care to all poor, pregnant women in the U.S. is about $1 billion compared to the $2.1 billion we as taxpayers will pay for the care of low birthweight babies this year. According to the Institute of Medicine, $3.38 is saved for each dollar invested in prenatal care for low-income pregnant women. As we continue to face budget realities on every level of government, it is time to focus our national efforts on cost-effective programs.

There is much work to be done to turn the infant mortality crisis around. Addressing this complex problem will clearly require the combined knowledge of the medical community along with the efforts of our governmental leaders on the local, state and federal levels.

Testimony

Infant Mortality

April 8, 1988

E. Frank Ellis
Swope Parkway Health Center
4900 Swope Parkway
Kansas City, MO 64130

Mr. E. Frank Ellis, Jr.

Summary of Testimony

Community Health Centers play an important role in identifying the health care needs of the communities and neighborhoods which they serve and in developing services to meet these needs. Health centers fill a gap in the health care system by serving low income and indigent patients who otherwise have difficulty receiving appropriate and timely care through other avenues.

The mission of the Swope Parkway Health Center is:

- to provide a wide range of quality medical and mental health services that are both geographically and financially accessible
- to promote the use of health services in a neighborhood rather than an institutional setting (such as a hospital emergency room -- an inappropriate, and costly, site for routine care)
- to reduce hospital admissions -- another costly health care service -- by promoting wellness and providing preventive health care

The Health Center sees about 30,000 patients a year and serves a predominantly low income, black population in central Kansas City, Missouri. The Center is sensitive to the cultural background of its patients. It is organized to provide a wide array of prevention and education services not generally available in the private sector. For the childbearing clients:

- Prenatal and parenting classes and nutrition classes are offered in site. A WIC clinic is available on site as well.
- In addition to the on-site services, the Center staffs two high school based clinics. These clinics work closely with teenagers who have a variety of social and economic problems. Many of these teenagers are pregnant as well.

Many problems contribute to the high rates of infant mortality in a population such as that served by Swope Parkway Health Center. Cultural, ethnic, and family background can interfere with pregnant women seeking health care. Other barriers include a mistrust of agencies in general, a lack of financial resources, and a lack of knowledge of community resources. These young pregnant women often have minimal understanding of the deliterious effects of how smoking, alcohol, drugs, and muptiple pregnancies in a short period of time can affect their health and that of their developing child. With so many social problems, receiving prenatal care is just not a priority.

Swope Parkway is an example of a health center playing a pivotal and integral role with other health care providers, local government, and the private sector in planning for and meeting the complex health and social needs of a high risk population.

BEST COPY AVAILABLE

History At Swope Parkway Health Center

The concept of neighborhood health centers dates back to the 19th century in the United States. The concept gained momentum in the 1960's in the wake of the Great Society programs and the Civil Rights movement. Within this political climate the Model Cities program was established in Kansas City, Missouri.

One of the initial actions of the Kansas City Model Cities program was to establish a health center to serve the inner city under Public Law 94-63. In November 1969, the Model Cities Neighborhood Health Center later to become Swope Parkway Health Center came into existence. Since its inception, the Health Center has been governed by a board of directors representative of the community it serves. The primary mission of Swope Parkway Health Center has always been to upgrade the health standards of the poor by; (1) providing a wide range of quality medical and mental health services that are both geographically and financially accessible and (2) promoting the use of health services in a neighborhood rather than an institutional setting. In addition, Swope Parkway is dedicated to promoting cost containment by; (1) preventing inappropriate use of costly emergency services and (2) reducing hospital admissions by promoting wellness and providing preventive health care.

In 1980, a community mental health center grant awarded to the center enabled the expansion of outpatient services and the development of inpatient, day treatment and consultation & education services. The Brookside Mental Health Offices, a satellite facility, opened in the same year. In 1981, Swope Parkway Health Center was designated by the Missouri Department of Mental Health as a full service center and as administrative agent for its service area. In 1984, a Health Maintenance Organization for Medicaid recipients was developed and implemented. That same year the Swope Parkway Health Foundation was incorporated to serve as a fund raising arm for the Center.

Swope Parkway Health Center provides a full range of medical, dental and mental health services as well as a full range of support services to a predominatly low income Black population in the central city portion of Kansas City, Missouri. In addition, Swope Parkway Health Center endeavors to provide quality services in a manner which is sensitive to the cultural background of its patients. Swope Parkway Health Center has always been and continues to be committed to serving high risk populations and is organized to provide a wide array of prevention and education services not generally available in the private sector.

Prenatal and parenting classes and nutrition classes are offered on site as well as a supplemental food program for women, infants and children (WIC Program). All services are under the clinical direction of a full-time medical director. In addition to the services and programs at the Main Center and the Brookside Mental Health Offices the Center staffs two high school based clinics in close proximity to the Health Center. These clinics work with teenagers who have a variety of social and economic problems and many of whom are pregnant. The Center also provides health and mental health services at Senior Citizen High Rise Apartments and Homeless Shelter Sites. Added examples of the Center's willingness to serve high rise populations are its contract with the Kansas City, Missouri Health Department to serve as an AIDS testing site and the opening of a residential care facility for chronically mentally ill in the fall of 1987. The Health Center has been serving the homeless since 1985 and is a recent recipient of the Stewart D. McKinney Federal Funds for the Homeless.

Description of the Community

Swope Parkway Health Center is located in the core of the Greater Kansas City metropolitan area which is a urban/suburban area spanning five counties on both sides of the Missouri/Kansas state line. The geographic area served by the Center covers approximately 6 square miles, extending from 31st Street to 95th Street from Troost on the west to I-435 on the east.

Although a concentration of light, medium and heavy industry may be found in the northeastern portion of the target area, the area as a whole consists of primarily older residential neighborhoods and small businesses. The population of the target area is approximately 182,000; 65% black and 35% white. In the service area 22% live below poverty level and have no public or private insurance; of the Center's 30,000 patients however, 78% live below poverty.

Although, Kansas City has experienced rapid suburbanization over the past two decades, medical services have remained relatively centralized in the City's core. Thus, while there are four private hospitals located within the Center's service area accompanied by clusters of physicians' offices most of these facilities serve primarily a private pay population.

Truman Medical Center, a public institution associated with the University of Missouri at Kansas City Medical School, and Children's Mercy Hospital located approximately 3 miles north of the designated service area are readily accessible to the population served by the Health Center.

PROBLEM

Kansas City has experienced a dramatic increase in its infant mortality rate, jumping from 12.8 in 1984 and 11.5 in 1985 to 16.1 overall in 1986. Within that overall increase is a change for the white population from rates of 10.1% in 1984 and 1985 to 12.8 in 1986 and a change for the Black and other populations from 16.9 in 1984 and 13.5 in 1985 to 21.2 in 1986. (Missouri Department of Health: State Center for Health Statistics, 2-9-88).

These figures give Kansas City the dubious distinction of being a statewide leader in Missouri for infant mortality--rates higher than the statewide rates (9.2 white and 17.5 Black/other) and even higher than comparable rates for Missouri's other major city, St. Louis (12.1 white and 19.9 Black/other) (Missouri Department of Health: State Center for Health Statistics, 2-9-88). These recent increases escalate rates that are already far higher than those set as national goals by the United States Surgeon General's Office (Office of the Surgeon General of the United States 1979) calling for a national infant mortality rate of 9.0 per 1,000 live births and for no county, racial or ethnic group to have a rate in excess of 12.0 per 1,000 live births by 1990. Low birthweight (less then 2,500 grams or 5.5 lbs) is also a problem in central Kansas City, an area which houses the major portion of Kansas City's poor. From 1982-86 the average low birthweight was 12.4 in Central Kansas City compared to 7.1 for non Central Kansas City, and a national and Missouri rate of 6.7.

Some of the immediate problems for low birthweight babies can be mental retardation, birth defects which may require surgery, blindness, visual and hearing disabilities, neurodevelopmental handicaps such as cerebral palsy and epilepsy, respiratory tract problems, prolonged and expensive hospitalization and the need to be rehospitalized during the first year. According to Children's Mercy Hospital, the cost of caring for low birthweight babies averages in excess of $1,000 per day. The human cost is great as well--nothing is as tragic as the death of a baby.

CONTRIBUTING FACTORS

It is apparent that there is a set of indicators of risk factors that when present, greatly increase the chance of a particular woman bearing a low birthweight infant. Included in those risk factors are maternal health status, health history, race, socioeconomic status, nutrition and lifestyle behaviors, with emphasis on smoking and substance use.

All these risk factors can be applied to a greater or lesser degree to the patient population the Health Center serves. Our experience demonstrates how cultural, ethnic and family background can interfere with pregnant women seeking health care. The role of the mother and especially the role of the grandmother can be another barrier to young women seeking early prenatal care. Their past experience will greatly affect the decision of their daughters to seek prenatal care. Other barriers to accessing health care include; mistrust of agencies in general and fear that an inability to pay will result in receiving substandard care, a lack of knowledge of community resources including social services, health services, educational services, a lack of transportation to medical appointments and a lack of any personal finances. Oftentimes there is no motivation for the pregnant women to seek health care because of fear of telling her mother that she is pregnant, exacerbated by her inability to enter the prenatal care system without parental consent. Not only is there an inability and unwillingness to access health care, but the information pregnant women have on the deleterious effects of lifestyle behaviors is minimal. For the most part, they are unaware of how sexual behaviors, smoking, alcohol, drugs, inadequate nutrition, excessive or inadequate weight gain and multiple pregnancies within a short time affect the fetus. Finally, our patients often have so many other social problems that receiving prenatal care is not a priority.

CURRENT LOCAL ACTIVITIES

Swope Parkway Health Center assumed the leadership in addressing the serious problems of infant mortality and low birthweight by establishing a community wide infant mortality program in 1985, which includes seven major providers of prenatal care services in the area. This project, called the Community Health Project, is concentrating on the following objectives: (1) reducing low birthweight, morbidity, mortality and prevention of birth defects by offering a multi-disciplinary prenatal curriculum (2) reducing historical barriers to care by developing active outreach programs to include assistance to young women and their families (3) increasing the number of prenatal visits to nine or more by providing transportation to clinic appointments, telephone counseling, nutritional and social services referrals, follow-up among agencies, home visits and (4) developing an evaluation tool to assess the progress of low birthweight infants during the first year after delivery.

The project team includes the project coordinator who is an R.N., physician consultant, health educator/social worker, nutritionist, secretary and van driver. At present the team works with a caseload of 480 young women who either are pregnant or who have delivered and whose infants are being followed for the first year of their life.

The Health Center also participates in a voluntary Kansas City Regional Maternal and Child Health (MCH) Planning group with funding through the Missouri Department of Health. In spite of these local efforts many gaps still exist in the prenatal care system in Kansas City. There is no followup on positive pregnancy results at the pregnancy sites and therefore no way to know how many mothers and infants do not receive any prenatal or postnatal care.

Many individuals do not know about the transportation provided by the Community Health Project and therefore transportation is still a major problem for many indigent patients. Agencies may track information internally but there is little exchange of information on a continuous basis among agencies. Data collection is not done in a uniform fashion which makes tracking mothers and infants even more difficult.

CASE STUDY

K.R., a 16 year old female came to the OB/GYN Clinic at Swope Parkway Health Center on October 14, 1987 complaining of a vaginal infection. On examination, she was found to be 20 weeks pregnant. Cultures for Gonorrhea and Chlamydia were positive and antibiotic treatment was started.

Her history revealed that prior prenatal care had been limited to a testing site visit in early August for a pregnancy test. On risk assessment, K.R. admitted to using crack and stated that her boyfriend was an I.V. drug abuser. She denied use of alcohol and I.V. drugs, but has been a 2 pack a day smoker for four years.

Her social and financial history disclosed that she had no insurance coverage and was not eligible for Medicaid. She was referred by the Health Center physician to the Community Health Project. Community Health Project staff was unable to locate K.R. on a home visit due to change of address and no one had knowledge of a new location. She also failed to return to the clinic for prenatal care.

She was lost to follow-up care until November 1987 when we were notified by a local emergency room that she had been admitted for head injuries believed to be the result of physical abuse. She was readmitted in January 1988 and had a C-section delivery of a infant weighing 1326 grams. She failed to return to the clinic for postpartum care.

Had K.R. been referred to the Community Health Project at the original pregnancy site visit, the following interventions could have altered the pregnancy outcome:

1. Community Health Project staff intervention to assure that first trimester and continual prenatal care visits were kept.
2. Community Health Project assistance in obtaining social service needs such as transportation, food stamps, etc.
3. Education concerning the impact of smoking and of drug use on the fetus with follow-up smoking cessation classes and professional counseling to assist K.R. in remaining drug free.
4. Home visits to monitor the health status of K.R., to assure appropriate nutrition, to monitor drug and cigarette use and to provide support for drug and cigarette abstinence.

CHALLENGES

The problems of infant mortality and low birthweight must be viewed in the larger context as well. Thirty-five million Americans live below poverty but do not meet guidelines for any governmental or private health insurance. This group includes spouses and children of employed persons and underemployed persons not covered by insurance. One out of four, or 25%, of the 35 million, are children who will receive inadequate care or no care during their lifetime thus carrying the tragedy into a new generation.

A comprehensive resolution to this complex and serious problem should be initiated immediately. To do so, however, requires maximizing the use of federal, state, county and city government funds which would necessitate a strong commitment to coordination of efforts on all levels. For example, federal Medicaid matching monies could be mandated to require that states coordinate their resources with local resources to place the problem of infant mortality on a top priority level. Such a commitment on the part of the political system would then enable Mental Health, Drug and Alcohol, Transportation, Social Services and Education agencies/departments to focus jointly on this issue. In addition , the private philanthropic community should be approached on a larger scale than in the past to seek their cooperation in working with both community health centers and other public/private agencies to address this serious problem.

Simultaneously, every effort should be made to promote recognition by frontline primary health care organizations, business, civic, philanthropic and social of the deleterious effects of low birthweight and infant mortality.

Finally, we are recommending that both federal and state agencies take the leadership in developing an ongoing advisory committee composed of frontline primary health care organizations, business leaders, civic and philanthropic leaders to propose strategies to address the increasing problems of low birthweight and infant mortality.

It is clear that meeting the challenge of low birthweight and infant mortality will only result from the dedication, maximization and coordination of all financial and human resources in our affluent nation.

TESTIMONY

OF

CAROLINE GASTON

PRINCIPAL/PROGRAM COORDINATOR of New Futures School

Before the

NATIONAL COMMISSION to PREVENT INFANT MORTALITY

April 25, 1988

Summary of Testimony by Caroline Gaston
for the National Commission to Prevent Infant Mortality

April 25, 1988

It seems essential that the Commission, in its recommendations on measures to prevent infant mortality, address the issues associated with adolescent pregnancy. The infant mortality rate for children born to teen mothers is 17.4 per 1,000, markedly higher than for women in their twenties.

Local education agencies can, and should, play a role in reducing the incidence of teen pregnancy and thereby infant mortality in several ways. Their activities, while including direct prevention efforts such as Family Life Education in junior and senior high schools and school-based health clinics, need to be both broader and deeper. Schools, beginning in the very early grades, have a major impact upon a child's feelings of self-worth and success. Teens who are successful in school, who stay in school, who have a positive self-image, who have hope for their future, who feel respected and valued, are far less likely to become pregnant than their peers who see little success in their lives. Schools need to be concerned about how they affect children in these areas as well as in academic areas. School systems should, additionally, provide pre-teens and teens of both sexes with broad-based prevention programs modeled after program strategies which have been demonstrated to be effective in changing behavior. These have almost all involved cooperation between schools and community agencies.

The role of education agencies should not stop when a teen does become pregnant. At New Futures School, an alternative junior-senior high school for childbearing adolescents in Albuquerque, NM, pregnant teens learn about the changes happening to their bodies during pregnancy, and accept responsibility for incorporating health practices which lead to good pregnancy outcomes. Regular prenatal care and good nutrition are emphasized. At the same time they are progressing toward a high school diploma, improving their self-confidence and goals for the future, and learning parenting skills. New Futures School is a comprehensive program which includes health services, health education, counseling, secondary school curriculum, on-site child care, and vocational education. A number of health care providers, human service agencies, and volunteers in the community work cooperatively with the school system to provide these services. New Futures School has had positive measurable successes. With 1320 deliveries in the last 7 years, the low birth weight rate has been only 6% to 9%, and there have been only 6 infant mortalities. The repeat pregnancy rate at one-year post-partum is only 6-10%.

Across the country, only a small percent of pregnant teens have access to comprehensive programs incorporating health services, intensive health education, counseling, and self-esteem development such as New Futures School provides. Widespread replication of the NFS model could play an important role in reducing infant mortality in the United States.

I am Caroline Gaston, Principal/Program Coordinator of New Futures School, Albuquerque, New Mexico. I appreciate the opportunity to testify about the role that local education agencies can play in preventing infant mortality.

Accross the country, one out of every six babies is born to a teen mother. According to a 1980 National Natality study, the rate of infant mortality of infants born to teen mothers is 17.4 per 1,000. A study in up-state New York found a rate of 20.1 for infants born to mothers 17 years of age and younger. These rates are markedly higher than rates for mothers in their 20's. My testimony today will focus on means to reduce infant mortality by addressing adolescent pregnancy issues. Schools, where most (although, unfortunately, not all) of teens 17 and younger spend a great deal of their time, should be expected to play an important role in reducing infant mortality by reducing both the rate of teen pregnancy and the negative consequences of adolescent pregnancy.

It is helpful to consider the issue of "prevention" of adolescent pregnancy as a Continuum of Prevention. We want to

Prevent teens from becoming sexually active
when that doesn't work
Prevent pregnancy by promoting responsibility
when that doesn't work
Prevent the negative consequences of teen pregnancies and reduce repeat pregnancies

Local education agencies have a role to play in all three strategies.

The factors leading to a teen pregnancy are often very complex. For that reason, a simplistic "just say no" campaign may not be effective. For most teens, a far more comprehensive approach is needed. Professionals with experience working with pregnant teens have identified a number of reasons for teen pregnancy - reasons which affect both males and females. Some of these reasons are

Lack of self-esteem and self-confidence and a feeling of hopelessness about the future;
Media influence;
Familial influences such as dysfunctional families, parent-teen conflicts, or parents' discomfort with talking with their children about sex;
Lack of knowledge about contraception and lack of accessibility to

contraceptives;
High dropout rates from schools and subsequent inability of teens to fill their time with socially acceptable activities such as employment and school attendance.

(Please see "Teenage Pregnancy: Action for Prevention, Prescription for Caring" which is appended to this testimony). Because of the large number of factors which may lead to a teen pregnancy, a comprehensive prevention strategy which addresses both males and females would seem to be most effective.

In recent years a large number of primary prevention programs have been developed. Some of them address only the first step in the Prevention Continuum while others address the initial two steps. Only a few of these program models have documented their success in terms of behavior changes (i.e., a lower pregnancy rate). Many more have documented increased knowledge about teen pregnancy-related information but, unfortunately, changes in knowledge do not necessarily bring about changes in behavior. We must identify and seek to replicate those programs where measured behavior changes have occurred. Examples of such successful programs include

Postponing Sexual Involvement - Emory University and Atlanta Public Schools

St. Paul School-Based Health Clinics - Ramsey Medical Center and St. Paul Public Schools

Teen Outreach Program - St. Louis Junior League and St. Louis Public Schools

Harlem Pregnancy Prevention Program - Hunter College, NYC

Adolescent Parent Prevention program - Greene County, NC Health Care, Inc. and Greene County Public Schools

School/Community Sexual Risk Reduction Program for Teens - University of South Carolina and Denmark-Olar School District

Ounce of Prevention/Parents Too Soon - Office of the Governor, Illinois, and many cooperating agencies throughout Illinois

Project Playback - Community Maternity Services, Albany and schools in several up-state N.Y. counties

It is important to note that each of these models involves cooperation between a school system and a non-school agency.

In addition to providing special primary prevention programs, there is more that public schools can do to reduce the incidence of adolescent pregnancy. A number of the contributing factors to teen pregnancy can be traced, at least in part, to school-related problems. Feelings of being "a failure", of not being valued or respected, are often fostered in the school system. These tendencies are being exacerbated by the current trend toward "school reform" and "higher standards" which, in many cases, asks students who could not jump a four-foot hurdle to now jump a six-foot hurdle in order to be "successful". The solution for many at-risk students will be to drop out of school, or to turn to other activities which, to them, appear to be ways to get attention, to be loved, to be successful. Many educators concerned with at-risk students, including myself, fear an increase in teen pregnancies. Indeed, a number of special programs for school-age parents across the country are reporting increased enrollments this year. Students who have failed a grade or who have dropped out of school are at much higher risk of teen pregnancy than their peers. In curriculum development, and staff training, and daily operation school systems need to be aware of the influence they are having on young people in their personal development and their perceptions of their role in the world as well as on their academic growth.

A third area in which school systems can impact upon the teen pregnancy rate is surprisingly, by providing quality pre-school education. The Committee for Economic Development, in its 1987 publication "Children In Need: Investment Strategies for the Educationally Disadvantaged" makes a strong case for the need to begin preventing a variety of adolescent problems, including teen pregnancy, with good pre-school education. The rationale is that many children begin the first grade behind their peers and/or with a low self-image, and are therefore likely to become the school failure, the dropout, the substance abuser, or the pregnant teen within a relatively few years. Follow-up data from the Ypsilanti Pre-School Project reveals that the teen pregnancy rate for former participants in this pre-school was very low.

The education system's responsibility for reducing infant mortality should not cease when a teen becomes pregnant. Let me focus the remainder of my testimony upon the third step of the Continuum of Prevention - reducing the negative consequences of a teen pregnancy. In so doing, I will describe the experience of New Futures School. New Futures School is an alternative school of the Albuquerque Public Schools. We are co-sponsored by a community-based non-profit organization, New Futures, Inc., a fact which I believe has been very important to our success.

In the last 7 years 1,320 NFS students, ages 12-20, have delivered babies. The low birth-weight rate has ranged from only 6% (in the 1986-87 school year), to 9% (in the 1982-83 school year). There have been only 3 neonatal (in the first 28 days of life) and 3 infant mortalities among those 1320 births. These are, we believe, impressive statistics. Let me describe the New Futures School program which has accomplished such results.

New Futures School is a diploma-granting junior-senior high school, providing traditional academic subjects with a non-traditional teaching style which emphasizes individual instruction and success-oriented teaching. Additionally, four different classes which focus on various aspects of parenting are taught, all for high school credit. A second component of New Futures School is the health component. Four nurses/health educators provide individual and group health instruction. We believe in teaching "love your baby before it's born" as the motivational factor which encourages young mothers to assume responsibility for incorporating health practices which lead to positive pregnancy outcomes. The regular school lunches are modified so that students can put into practice the lessons on nutrition they are learning in Personal & Child Health class. Students must be receiving prenatal care, either in the clinic provided in New Futures School by the University of New Mexico School of Medicine or by another health care provider of the student's choice. NFS nurses keep closely in touch with the teen's doctor and monitor the teen's understanding of her health care instructions. Each day, the NFS Nurses Office is busy with nurses giving practical health instruction to mothers with babies on their laps. Babies who need medical attention are immediately referred. Mothers are taught how to handle minor health problems, and how to tell the difference between minor and major ones.

A third component of New Futures School is the counseling component. Five counselors provide individual and group counseling. Many pregnant teens face overwhelming personal and/or family problems which make it very difficult for them to focus on the pregnancy, proper health care, and parenting. Counseling makes an important contribution to positive health outcomes by assisting young mothers to cope with these problems. Counseling also emphasizes the need to mature rapidly, to learn decision-making skills, and to develop a more positive self-image, all of which help the pregnant teen to have better health outcomes, and the young mother to be a better parent.

A fourth component of New Futures School is on-site child care. Each pregnant teen spends one class period per day for nine weeks working in the NFS Teaching Loving Care nursery, helping to care for the babies who range in age from two weeks to six months. Outside observers have commented on the role this responsibility plays in helping the pregnant girl to mature rapidly and to become interested in the health of the child growing inside her. Teen parents spend part of their parenting classes helping to care for children in one of the two NFS Day Care Centers which serve "crawlers" and "walkers". The NFS Day Care Centers are learning areas in which students receive practical instruction in child care which reinforces the parenting and child development theories they learn in the classroom. NFS nurses make daily checks on the health of children in Day Care. By having child care on-site, the young mother can continue in school and still breastfeed her baby. One half of the NFS teens who delivered last year chose to breastfeed.

No student is required to attend New Futures School. All of the 450 pregnant and parenting teens who enroll with us each year are with us by choice. They could remain in their home schools, or stay at home. It is significant, I think, that 40-45% of NFS students have been school drop-outs before they enroll with us and many of them had dropped out before they became pregnant.

All NFS services are provided within a framework of caring and respect for the teen. Teens are not "lectured to", but are enabled to involve themselves in the processes of learning, maturing, and good health practices. In order to care for and love a child, one must care for oneself - "you cannot give what you do not have". Many of our students have experienced too little nurturing in their own lives. We nurture our students so that they will be better able to nurture their children. It seems to work!

The following factors have been identified as being key to the success of New Futures School

* a valuing, caring relationship between students and staff
* comprehensive, coordinated services, each of which help the other to be more effective
* a philosophy of working with young people, not at them or to them
* emphasis on the growth of self-esteem and personal decision-making
* opportunity to work with the teen mother from pregnancy through the early parenting period
* on-site child care
* active community involvement
* a committed, skilled staff

There are some other communities in the United States in which similar programs for childbearing adolescents exist. They are, however, too few. Yet the key characteristics I have described could be replicable in most communities. The particular structure the program takes would vary from community to community, dependent on availability of resources, patterns of power structure, and willingness to cooperate. I would hope that this Commission, in its recommendations, will encourage local education agencies to play an active part, in cooperation with other agencies, in reducing infant mortality by providing accessible health care, health instruction, parenting education, child care, and counseling to school-age parents.

Communities also need to provide similar services to teen parents who drop out of school. I believe that an alternative school setting is the best mechanism because of its ability to provide a nurturing environment, to focus needed services, and to draw dropouts into the process.

I have attempted to present a number of ideas to you in this short time. I would like to close by outlining some of the key points I have presented. Before I do so, I would like to thank the members of the Commission for the time you are giving to this very important topic. The future of America is its children. For a strong America, we need for all of our children to be strong, healthy, and well-educated. This Commission is making an important contribution toward this end. I am pleased to have been a small part of your effort.

Outline of Key Points

- Because teen pregnancy rates are high, and infant mortality rates are markedly higher for teen mothers, it is important to focus upon teen pregnancy as a part of efforts to reduce infant mortality
- School systems can play a significant role in both the prevention of teen pregnancy and the reduction of its negative consequences
- Programs to reduce the negative consequences as well as to prevent initial teen pregnancies are best accomplished by cooperative efforts of school and community
- The causes of teen pregnancy are usually complex; therefore, comprehensive prevention strategies which address both males and females are needed
- There are primary prevention models which have reduced teen pregnancy rates in their communities; it seems advisable to adapt these model for local use rather than trying to "reinvent the wheel"
- School systems need to be alert to the danger that some of their policies and procedures can lead to adolescent problems, by causing children to think of themselves as worthless or as failures
- Quality pre-school programs can reduce the incidence of many adolescent problems - including teen pregnancy
- New Futures School has had documented success in reducing infant mortality, low birth-weight rates, and repeat pregnancy rates among teen parents
- In order to have better health outcomes and to be better parents, teens need to internalize or "buy into" the ways to do so rather than to simply be told to do certain things
- A comprehensive coordinated program which includes parenting education, individual and group health instruction, counseling, academic education, and on-site child care is most effective with childbearing adolescents
- On-site child care provides an opportunity for practical instruction in child care, and role modeling of care; it also encourages young mothers to breastfeed
- Many young mothers need to develop positive self-esteem and to learn to handle their personal problems; they need nurturing in order to be able to nurture a child
- Programs are needed to serve out-of-school teens as well as those in school
- An alternative school setting is a very effective program model because it can provide needed services in a nurturing environment, and because it is more likely to draw in the dropout and potential dropout
- There are a relatively small number of school systems which provide needed special services to childbearing adolescents; many more are needed in order to prevent infant mortality in the United States
- We cannot afford to ignore any part of the Continuum of Prevention - we need to try to prevent adolescent sexual activity; to prevent teen pregnancy; and to help teen parents to have better health outcomes and to be better parents

MCH

2001 L Street, N.W.
Washington, D.C., 20036
202-466-8960

Association of Maternal and Child Health Programs

TESTIMONY TO THE NATIONAL COMMISSION TO PREVENT INFANT MORTALITY
CHICAGO, ILLINOIS
25 April 1988

Presented by: William H. Hollinshead, M.D.
President

The Association of Maternal and Child Health Programs, which represents the state public health programs for mothers and children, appreciates the opportunity to participate in the work of the Commission. We agree that infant mortality is a critical, and preventable public health problem in America. We strongly endorse the comprehensive approach that the Commission has taken with the problem, which is very much in keeping with the mandate and responsibility of Title V programs to assess health needs and develop needed health programs. In fact, many Title V agencies have recently convened state level task forces or commissions on infant mortality, which have resulted in better policies and programs, and real improvements in access and quality of maternity services. We are confident that similar improvements at the national level will result from the work of this Commission.

The Title V programs believe that it will take a new societal commitment from all sectors, public and private, business and media, national, state, and local to support an effective American approach to infant health. Together, we must establish long-term child health goals for the nation. We believe the United States can have the healthiest children in the world by the year 2000.

In the next decade, we can assure that all women and infants are welcomed into a comprehensive, and comprehensible, system of care which is effective, humane, and risk responsive. Maternity and infant health care can be linked to the social and financial benefits that enable families to protect their own well-being and nurture their infants. Thus, we are joining with many others here in a long-term national commitment to leadership and excellence.

In 1988, we must also focus on the immediate opportunities we have to help every baby to be born healthy into a family and community that can support her optimal health and development. There are critical leadership roles for federal, state, and local government right now. Title V, Medicaid, Community Health Centers, WIC, and Family Planning are the key health related programs we have at hand today. If we can support and coordinate them better, they offer means to achieve immediate, significant reductions in infant mortality. Thus, we are part of a strong new maternal and child health coalition, designed to strengthen and integrate all of these programs.

Title V of the Social Security Act is unique in its mandate to assess the needs of all mothers and children, to set standards for care, to develop and coordinate provider systems, to provide information and education for both families and providers, and to provide an accounting of the impact and effectiveness of health programs. In recent years, we have good examples of this kind of leadership and accountability in many individual states. However, a national commitment to improve infant health must include a reconfirmation of this public health leadership role in all jurisdictions, and a reinvigoration of the national information base we all need to plan and evaluate our efforts.

Recent improvements in Medicaid coverage and policies are a major investment to reduce that the financial barrier to care for many low income women and children. But we all know that coverage alone does not assure care. Community Health Centers, WIC, and Family Planning sites also reach many families and address kev elements of the low birthweight and infant mortalitv problem. Private providers, doctors and midwives, are also critical to any serious effort to reach all parents We all know that some professionals are withdrawing from obstetrical practice. As state maternal and child health officers, it is our job to assure that coverage and providers are brought together into a comprehensive package that will reach all women and families living in all sorts of communities in our states. The Title V programs plan, integrate, and fill critical gaps for families. Unfortunately, our mandate has been far beyond our means in recent years. We are now preparing a maternity care assurance initiative which will greatly strengthen the public health and and community efforts to tailor maternity services to meet the needs of women and families where thev live.

The Alabama Title V program has exerted this kind of leadership in the state with the worst infant mortality rate in the nation in 1986, and where one-third of counties have no organized obstetrical care available. Although the Title V program provides prenatal care for over one-third of the pregnant women in the state, it reaches only two-thirds of those in need. Supported by a coalition of forty-four professional, provider, civic and religious groups, the program has developed proposals to improve those health department and Medicaid programs. The Alabama legislature has mandated that the income eligibility limit for Alabama Medicaid will be increased to 100 percent of the poverty level to pregnant women and infants. Prenatal and child health care are now required to be available in each county's health department.

Title V leadership can also support the efforts of local governments and communities to develop and tailor service systems to meet community needs. A few years ago, the city of Holyoke, Massachusetts was in crisis, with a very poor population, a large Latino community, and no obstetricians taking Medicaid patients, the city had the highest infant mortality rate in the state. Less than half of Holyoke's pregnant women received prenatal care in the first trimester of pregnancy. The state Title V program provided the data the community needed to analyze the problem, and the support to build a community coalition. Today there is a new prenatal clinic, a teen drop-in center, and school-based health programs operating in poor and Latino neighborhoods of Holyoke. These efforts are coordinated by an outreach/referral and case management network of the Community Health Center, WIC, Family Planning, schools, social services, and other community groups. The system is supported by Title V and private funds, including increased Medicaid state and federal Title V dollars support this system. This is the kind of result that federal, state, and local partnerships can achieve, and that maternal and child health leadership is uniquely placed and empowered to evoke.

In summary, the AMCHP wants to emphasize four critical elements of a national strategy to prevent infant mortality:

1 We must all agree that excellence in infant health is a national priority, and that active, enthusiastic investments in maternal and infant care are good for our society

2. We must lead American clinical care providers toward a simple, accessible, risk-responsive system of maternity care.

3. We must reinvigorate public health leadership and Title V programs for reduced infant mortality, including stronger mandates and accountability for federal, state, and local health authorities.

4 We must strengthen our information base on care and outcomes, to account for our programs and funds.

Title V programs are working on each of these areas, using this Commission as a primary source of information and leadership.

WHH:VCD
April 1988

TESTIMONY

National Commission
to Prevent Infant Mortality

April 25, 1988
Chicago, Illinois

Submitted by:

Barbara D. Matula
Director
NC Division of Medical Assistance

We have taken major strides to combat infant mortality in the past 18 months since passage of enabling legislation to expand Medicaid eligibility for pregnant women and children.

States should be commended for their quick response to this urgent need and the creativity shown in developing new approaches to eligibility, service delivery and outreach.

The National Governors Association with the staff support of Ian Hill is studying the States' responses to expanded Medicaid eligibility and has reviewed the innovative approaches undertaken by various states. The preliminary findings show, however, that a number of barriers to receiving early and appropriate prenatal care still exist. Cited in the draft report are reasons for low participation:

- Ineffective outreach
- Lack of transportation
- Lack of knowledge of program or of pregnancy
- Inconvenient clinic hours (because of work or school)
- Lack of child care for other children
- Delays in getting appointments
- Inability to speak English
- Fear of deportation
- Difficulties in qualifying for Medicaid stemming from procedural denials, i.e., using AFDC methodology to determine eligibility: absent parent and parental financial responsibility

- Eligibility workers not located where care is given
- Welfare stigma attached to Medicaid
- Difficult and complex application process requiring extensive verification and often more than one visit
- Waiting periods of up to 6 weeks
- Redetermination of eligibility

The presemptive eligibility determination process overcomes some of these problems on a limited temporary basis.

- Moves the initial intake point to certain provider sites.
- Grants women a limited period of coverage for limited services rendered
- Requires states to adopt complex systems for determining presumptive eligibility periods of authorization (five, fourteen or 45 days

In the NGA report over 20 States' best practices were highlighted to serve as model approaches to minimizing or overcoming some of these barriers.

The diversity among States and their Medicaid programs and populations served is often a subject of criticism, but in many instances, the States, acting as laboratories can and do develop approaches to problem solving that would not easily be accomplished at the National level.

Infant mortality, however, is a national problem, and one which richly deserves national attention, direction, and support. This is why my first recommendation to you is that we conduct a major campaign at the national level to inform and to educate the American people on the urgent need to prevent premature births and infant deaths and ways to do so.

States can, and in varying degrees do, conduct outreach efforts to inform women of the availability of Medicaid services if they are poor and pregnant, but they are less apt to be able to educate the broadest base of their population to the benefits of prenatal care, nutrition, personal health habits, etc. This educational "blitz", if you will, is needed across the country, enjoying the highest level of visibility from public figures who can capture the attention of the American people. In a very short time we brought AIDS into the public eye; surely we can do the same or better with the lives of our children.

Assuming we have a well-informed public, our next challenge is to bring those who cannot afford the cost of health care into a rational and well-rounded service delivery system.

The federal enabling legislation in OBRA 1986 and again in OBRA 1987 was "revolutionary" in that it broke the link to welfare payment levels for Medicaid eligibility and recognized the federal poverty level as an indicator of need for services. It gave states new flexibility in determining eligibility by

- making resource or assets tests optional
- granting eligibility based on income up to 185% of poverty
- allowing presumptive eligibility to be granted for limited time periods
- allowing States to continue eligibility throughout pregnancy without redeterming eligibility if there was a change in income.

Our brief experience with this new flexibility leads me to another set of recommendations that would further remove barriers to eligibility for services.

- Eliminate the use of assets tests for pregnancy-related services. This is the most cumbersome and time-comsuming element of the eligibility determination process requiring verification of bank accounts, automobiles, life insurance policies, property records, etc.
- If a pregnant woman is uninsured and has income of 185% of poverty or less, she should qualify for pre and post natal services regardless of where she lives.
- Phase-in a national income standard of 185% for Medicaid eligibility over five years for pregnant women and infants. We can no longer afford to allow women in poorer states to have poorer pregnancy outcomes.
- Grant eligibility status on a continuing basis throughout

pregnancy and for the first year of life for infants. This would eliminate the need for redeterminations of eligibility at six month intervals or if there is a change in income and would assure uninterrupted care plans and payment for those services.

- Simplify the presumptive eligibility process through the use of a single simplified form for both the inital and final eligibility application. This would eliminate the need of additional visits by the applicant and the need for five and fourteen day time limits.
- Remove the restriction on outpatient services covered during the 45 day presumptive eligibility period.
- Waive the 4-D (absent parent identification) requirements until after the birth of the child.
- Waive parental financial responsibility for minor pregnant children living at home, and cease parental financial responsibility for pregnant 18-21 year olds living at home as does Title IV-A.
- Mandate referrals between WIC and Medicaid to ensure adequate nutrition for pregnant women and children.

Finally, access to care and the identification of appropriate services to pregnant women and children need additional national commitment and support.

- Urge the review of reimbursement plans to encourage increased participation of providers.

- Develop a package of services that can serve as a model in financing appropriate pre and post-natal care, with such a package to include case management, needs assessment, childbirth and parenting education, family planning and support services, such as transporation and child care.

- EPSDT - the Early, Periodic Screening, Detection and Treatment program for Medicaid eligible children is a excellant model for well-child care. There are two problems in making EPSDT services available to children: one, it is not automatic but rather must be requested by the parent, and two, it is subject to limits on services a State may have in its overall plan. I would recommend that each child be granted automatic EPSDT eligibility and that service limits not apply.

Taken together, these recommendation would help ensure access to needed care for the most vulnerable of our population and improve outcomes for future generations.

TESTIMONY OF

SISTER JEANNE M. MEURER

BEFORE THE

NATIONAL COMMISSION TO PRESENT INFANT MORTALITY

CHICAGO HEARING

APRIL 25, 1988

Sister Jeanne Meurer

Summary of Testimony

Reducing infant mortality and lowering low birthweight rates among high risk pregnant women can be done, as evidenced in a number of successful programs throughout the country. The effective approaches used in these programs need to be replicated widely by the health care establishment and need to be supported by the public programs that finance or directly deliver services to such populations. Unfortunately, however, numerous problems exist that prevent these effective approaches from reaching their potential.

Women at high risk of developing problems during pregnancy, delivery, and during the postdelivery period, and their newborns who may also be at risk for complications, require special attention. They need a comprehensive set of services that responds to their particular problems. The childbearing women and their babies served by the Ruskin Health Center in central Florida are such a high risk group. This clinic serves a rural, low income, and predominantly migrant and non-English speaking population. Yet, the incidence of low birthweight was reduced by 50% in these very high risk clients. The rate was lowered to 3% of births, while at the same time the rate for the state of Florida was 8.1%.

How did this happen? The key to the Ruskin Health Center's success lies in the continuity, comprehensiveness, and quality of care delivered to the clients, and in the sensitivity of the staff to the needs of their patients:

- Programs for the families were conveniently located and accessible. They were housed in the same facility. This is critically important for a poor family, especially in rural areas, since transportation can be a major barrier to receiving health care services for the poor.
- Maternity care was generally delivered by certified nurse midwives, and the women developed a close relationship with their attending midwife. This relationship was important in the development of trust and encouraged the women to take care of themselves and their newborns. In addition, staff sought out families and kept track of them to be sure the women kept their appointments.

Unfortunately, funding was cut for this demonstration program, causing a reduction in the number of nurse midwives on staff. The low birthweight rate rose to 8% the next year. When a demonstration is successful, it should be supported, not cut. Those making funding decisions - local, state, and federal authorities - need to be made aware of such programs' effectiveness and value.

Mr. Chairman and members of the committee, I am Sister Jeanne Meurer, Assistant Professor in the Department of Family and Community Health in the College of Public Health at the University of South Florida. I am a practicing Certified Nurse Midwife who has provided care for poor pregnant women for the past 18 years. In addition, I have been a nurse in Maternal and Newborn Care for over 35 years providing direct care as well as serving as a nursing consultant in the areas of Maternal and Child Health both nationally and internationally.

Thank you for this opportunity to express my views, on the important issue of Prevention of Infant Mortality. I would like to tell you this afternoon about a successful Federally funded program for rural and migrant women, how the incidence of low birth weight was reduced by 50% and about the estimated savings to the county, state and Federal Government. I would also like to tell you why this program failed. In the final part of this presentations I would like to make some recommendations from a health care providers point of view, in other words from someone who works daily with poor and needy women.

First, I would like to tell you why so often we health care providers have so much difficulty reducing the low birth rate, despite all the advances in medical science and technology. In order to provide prenatal care we must have programs for the families that are conveniently located and accessible. Health centers and clinics need to have comprehensive programs that are housed within the same facility. Let me just give you an example of the real world for poor families. As a pregnant mother who lives in a rural town, you may have to travel 25 miles or more to get to the center for care, but before you can receive care you must get your medicaid clearance, and that may be in another part of town, or at the county seat many miles away. Before final clearance, you may travel to the welfare office, this is usually in a different department and often at a different location. If you are eligible for food stamps or WIC another building in another part of town is the destination for you. You have no car, and the public transportation in rural areas is not as regular as a city or you may make as many as 5-6 transfers to get to your destination.

You may have a car, but the bread winner of the family must use it to go to work, and all the agencies have hours only from 8:00 a.m. to 4:00 p.m. or you may have a car but no money for gas or just enough gas for one trip and usually to get all this paper work done it takes many trips and several days. Just to make this scenario more realistic, you are an immigrant who speaks no English and the agencies do not have translators in your language. Is it any wonder that women can not get prenatal care early or they get it too late or not at all? I would suggest that if these essential services for poor women were housed in the same facility or in a geographical location that people could walk to, care would improve dramatically, first for the family, but for me as a provider. My time and care would be more efficient and cost effective.

There are ways that the integration of care services can be planned, and I would like to describe for you a successful demonstration maternity project. The health center I worked in is located in a rural area in central west Florida with a tertiary medical center approx 25 miles away.

The care provided at this center was by a group of certified nurse midwives and a consulting obstetrician for medical problems, the health center had the support of registered nurses, certified childbirth educators, outreach workers, social service, nutritionists from the WIC program and supportive staff such as lab, pharmacy and clerical staff. This team served not only the pregnant women but the entire client population of this center. The secret of the excellent outcomes I am about to give you is that continuity, comprehensiveness and quality care was the "gold standard" for the operation of this maternal program. Continuity of care with emphasis on consistent providers throughout the prenatal, birth, and postpartum experience is the answer. A consistent provider of care not only provides continuity of care, improves the quality of prenatal care by starting care earlier and having a better attendance in the clinics, but a culturally sensitive educational program for the families was provided.

After 15 months of operation this program was able to reduce the LBW to 3/1000 births, while at that same time the state of Florida's LBW rate was 8.1 and Hillsborough County was 8.2. Why the difference?

Access to early prenatal care with all the support services available in a conveniently located place as well as constant staff that reached out, sought families, and provided care was the answer. The outreach program utilizing community workers was aggressive in their approach to entering women early into the prenatal program, and monitoring to be sure that women kept their appointments. All the services they needed from medical to social were housed in one facility, this facilitated the maximum use of resources, and families were not lost to the system. The other essential component of this program was that the majority of the births were attended by the certified nurse-midwife in the tertiary hospital. The reason that this is so important to mention is that the pregnant women developed a close relationship with the nurse-midwife, and were active participants in their care. The incentive for remaining healthy assured them of having a nurse-midwife attend their birth. Another important aspect of this program was the early discharge program where the average length of stay in the hospital was 10 hours.

The in-hospital cost savings of a 10 hour stay compared to a three day hospitalization is great. The outstanding factor in this part of the program was that the return postpartum and newborn visit at 3 days was 99%. The reason is simple, women had been educated to assume responsibility for their own care and that of their children so they kept the appointments. I might add that I am describing a population of women who are poor, young, with limited education, and 1/3 are migrants.

In dollars and cents, and in human emotional life what are the benefits of such a program as the one I have just described? We estimated that in one year we were able to prevent 25 LBW babies from being born, thus eliminating the use of the neonatal intensive care and saving $375,000. This was calculated on the average neonatal intensive care cost at that time (1984) of $15,000 per newborn. This savings is comparable to the recent study which was reported in the American Journal of Obstetrics/ Gynecology in January, 1986.

I wish I could tell you that the Florida demonstration program is continuing and that the continued reduction of low birth weight babies is taking place. However, due to financial cutbacks the comprehensiveness of the program and the staff of nurse-midwives was reduced. The result of this cutback was that the following year the low birth rate again rose to 8% the same as before the program was initiated. This should not surprise you as this has happened before in other demonstration programs. One of the most notable examples was the 1960 Maderia project in California. This program demonstrated that the provision of comprehensive care with certified nurse-midwives as part of a team reduced the LBW rate, but after 3 years the program was closed due to financial restraints and subsequently the rate rose to what it was prior to the initiation of the program. I ask each of you on the committee why do we let history repeat it itself? I am sure that you are all familiar with other demonstrations programs that were successful, but once the monetary support was gone the program floundered and closed?

There is sufficient documented evidence that demonstration programs like the Maderia program in California program and the Florida program just described which support the thesis that provision of accessible, comprehensive prenatal care by certified nurse-midwives does indeed lower the LBW rate and ultimately the infant mortality rate.

The Institute of Medicine Committee to Study Prevention of Low Birthweight, 1985 recommends "that more reliance be placed on nurse-midwives and nurse practitioners to increase access to prenatal care for hard-to-reach, often high risk groups. Maternity programs designed to serve high risk mothers should increase their use of these providers."

I would now like to present some observations and recommendations:

1. Don't stop demonstration programs that are successful
2. Use outcome data for planning and continuance of successful demonstration programs.
3. Data collection and evaluation needs to be continued even when changes are made in the original program.
4. When demonstration programs are successful, support them financially and provide assistance to the state, county, and local authorities on how they can continue the successful programs. Good data such as lowered rate of preterm babies, increase in prenatal visits, improvement in infant mortality, and are not measured by the dollar amount alone. The long term impact of providing money for preventative

health services is recognized in theory by all of us here, but not in the practicality of continuing a program based on outcome data.

5. Provide adequate medical backup for programs that provide perinatal care to moderate to high risk women. This is especially true in rural areas, nurse-midwives and nurse practitioners can not practice in isolation to the rest of the health care community. They must be able to provide the same standard of care to the rural as to the urban populations.

I want to thank you Mr. Chairman and the committee for giving me this opportunity to present to you as a provider of care for poor women and infants, what I believe we must continue to do in order have better and healthier babies for the future. I urge you to continue to have the work of this most important commission continue, as it has given all of us health professionals the impetus to continue to work in reducing the Infant Mortality in this nation.

One of the outstanding poets of this century spoke to all of us when he said "The child cannot wait. Many things we need can wait, but he cannot...to him we cannot say tomorrow, his name is 'today'" (Gabriel Mistrail).

I would say to you that the cry of our infants is "today" and the dedication of our efforts must correspond to the needs of mothers and their babies.

The efforts of all of us legislators, politicians, policy makers, and health professionals will determine the future of society. It is in our hands what happens and what we will do to make it happen. I do believe that the National Commission to Prevent Infant Mortality is providing the direction for us. I hope and pray that the plans for a healthy nation of mothers and babies will be realized by all of us.

NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

Hearing - April 25, 1988

Richard W. Riley

I appreciate the invitation to testify before this Commission on which I also have the pleasure of serving as a member.

One of the topics on which I have been requested to speak is the "how to" of setting state priorities. As Governor of South Carolina from 1979 to 1987, I endeavored to promote priorities which would have short and long range significance. It was my intent that South Carolina could become more proactive in planning and implementing strategies which would prevent illness, dependence and disability.

These are not easy priorities to sell because they lack the urgency of a crisis. And, results generally take years to materialize. This certainly is the case with reducing infant deaths and disabilities. I can say proudly, however, that through perservance and commitment, we have been able to dramatically reduce the infant death and disability rates in South Carolina. (See attached for details)

A basic need when attempting to set state level priorities is the development of good, solid information to demonstrate the need and/or the problem. Projecting results into the future and projecting future costs to the state are essential to the ability to convince others that action must be taken now.

Sustained policy level leadership is critical and it is needed in both the executive and legislative branches of government. A prevention issue is easy to spotlight for a day or a week, but support is difficult to maintain over the long haul.

I have submitted several recommendations for the Commission's consideration. Briefly, these recommendations deal with three areas:

1) There is a clear need to establish a national policy which assures that all pregnant women and infants are provided access to health care and that no pregnant woman or infant shall be denied access to health care due to an inability to pay. In my view, such a policy should state that categorical eligibility restrictions, such as family composition and employment status, should not result in denial of health care for poor pregnant women and infants. Additionally, the states, the federal government and private sector employers should share the financial responsibility to provide health care for pregnant women and infants.

2) Every effort should be made to identify and eliminate "system" barriers which discourage access to prenatal care. By system barriers, I am referring to: a) lengthy and complex eligibility procedures; b) lack of effective coordination of needed services (such as Medicaid and WIC); and, c) a failure to manage care so that appropriate services are accessible to pregnant women and infants with special needs. The Southern

Regional Project on Infant Mortality has released some special reports on the eligibility issue and the WIC/Medicaid issue which will be helpful to the Commission in addressing these issues.

3) The Commission may also want to consider recommending the establishment of a public/private sector joint endeavor which would provide needed information on prevention strategies. Too often, we lack solid information which identifies a problem or which would help to promote preventive health care. Research and/or projects which are properly evaluated could help provide needed information and enable us to remove barriers and to more effectively advocate for the type of "upfront" investments which will help to reduce infant deaths and disabilities.

Some of these recommendations will call for federal mandates while others will not. Issues of national significance, such as access and financing of health care, redesigning the eligibility process and adequate funding of nutritional needs, will need to be addressed at the national level. National funding issues will require a sharing of responsibility between the state and federal governments and the private sector. Issues of service coordination should be jointly addressed by states and the federal government since the cooperation of both will be necessary to successfully implement coordination strategies.

Thank you for the opportunity to share these thoughts with you.

STATEMENT OF DIANA ROBINSON
Center for Successful Child Development

Governor, Honored Guests and Distinguished members of the panel. I am here to speak on the behalf of the babies born and those yet to be born to the women of my community. A community where 20,000 residents are forced to live in an area that totals less than two miles. Of the 20,000 residents,69% are children. Many of these babies face an uncertain future, as they enter the world without the benefits of proper pre-natal care, low birth weights and the lack of even basic necessities that are crucial to their development and survival. These babies will grow within a community were poverty and despair is quite often a way of life. They will inhabit buildings that are unsafe, poorly maintained and ventilated, roach and rat infested and where there is little room afforded for normal play.

The question before us today is what is the government's role in reducing the growing number of low-birth weight babies? Government programs such as W.I.C. (Women, Infant and Children Food Supplement Program) that have been funded to promote healthy diets among pregnant mothers and their infants have lost sight of the human aspect of those they serve. Many times pregnant mothers and mothers with small infants that they must bring with them to the W.I.C. offices, are forced to wait for hours for the coupons. This further increases their frustration and frequently causes mothers to give up, thus not receiving this important and necessary services.

For some who are successful in participating in the W.I.C. program, they are often penalized. Babies who gain weight too quickly are not allowed to continue receiving the added help. This situation only causes mothers who cannot afford to purchase dairy products that are important to the bone development of their babies, to exclude milk and other forms of calcium enriched foods supplied by the coupons, from their children's diet.

Pregnant moms who do receive W.I.C. coupons often have other children in the home. These mothers have little choice but to use what is purchased with the coupons to supplement the already poor diet of their other children, thus leaving very little if any for their own consumption.

The AFDC is yet another government sponsored program that has lost sight of the human aspect of those they serve. Here again those who come to AFDC offices in search of some relief to the poverty they suffer are often met by overworked, hostile case workers, who only serve to add to the humiliation that engulfs the lives of the poor. Women who are hungry and in need of emergency food stamps to purchase food for themselves and their children are often forced to wait anywhere from 30 to 60 days until their case has been considered.

Another influencing factor is the environment residents are forced to live in and rear their children. In the battle over who shall control the management of public housing, the only losers are the residents and their children who are now even denied the right to properly maintained, safe and affordable housing. And the list of inhumane treatment suffered by the poor goes on and on.

How can we a so-called just and humane society continue to ignore the cries of the innocent? Until we as a society take responsibility for the problems of the poor, then their despair will continue to eat away at the very fabric of this great nation.

It is, therefore, my belief that it is our shared responsibility to promote and to aid social agencies and programs that work, and to redefine those who have lost sight of their purpose, in their efforts to bridge the gap of despair for the children born into poverty. We must work together to insure that their cries are consoled, that their hopes for the future give way to triumphs, and that their fears are quieted with compassion.

Thank you.

Chicago Tribune

FOUNDED June 10, 1847

STANTON R. COOK, *Publisher* CHARLES T. BRUMBACK, *President*

JAMES D. SQUIRES, *Editor*
JACK FULLER, *Editorial Page Editor*

F. RICHARD CICCONE, *Managing Editor*
LOIS WILLE, *Associate Editorial Page Editor*

COLLEEN DISHON, *Associate Editor*
DENIS GOSSELIN, *Associate Editor*

14 Section 1 Monday, September 7, 1987

Voice of the people

Human story at Robert Taylor Homes

CHICAGO—I am writing in regard to the PBS documentary "Crisis on Federal Street." This rebuttal is on behalf of Robert Taylor Homes residents who believe as I do that the time has come for the human side of this much-publicized story to be told.

Robert Taylor has been home for me and my family for almost as long as I can remember. I have seen during the years much that the media and the rest of the general public have chosen to ignore.

In a sense, Robert Taylor is a community within a community. Although there are some who believe "we are a people at war with each other," I have found that we are a people strangely united by the devastation inflicted upon us. We are a people who have withstood insurmountable odds but have somehow continued to survive. We are a people consisting mostly of single-parent households, headed by women. We stay only because Robert Taylor offers a way to keep our families warm in the winter and together.

Unjustly, we are blamed for everything, from the upkeep of the buildings to the very problems that face CHA administration. We are labeled lazy, unclean and uneducated, all of which is totally unfounded. Because most of us have to depend on public assistance, we are thought of as unproductive, a useless part of American society.

But take note, America, for in our midst exist some of the most talented artists, musicians, interior designers, journalists, business administrators, seamstresses, cooks, furniture makers, plumbers, electricians, fashion designers, singers, hair dressers and more. The only difference between us and those who perform these tasks for a living is a degree and a chance.

We are a diverse community, one which deserves admiration for the strength and the courage we have shown. We are survivors. We have to be, given the dehumanizing injustices inflicted upon us each day. We are a people unlike any other, for the day shall come that the sleeping giants of Robert Taylor shall awaken and take mainstream America by storm.

How can we, a so-called just and humane society, continue to judge a community on the basis of biased documentaries and statistics that give only negative and dehumanizing views, yet are thought to represent all of the people of the Robert Taylor? Until we, as a society, take responsibility for the problems of the poor, we shall continue to feed the prejudiced and stereotyped behavior that plagues this great nation. As society continues to close its eyes and harden its heart toward those who are less fortunate, we do an unforgivable injustice to all who have dreamed and strived in their pursuit for a piece of the American pie.

Diana Robinson

STATEMENT OF

DR. WILLIAM L. ROPER

ADMINISTRATOR

HEALTH CARE FINANCING ADMINISTRATION

BEFORE THE

NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

Chicago

April 25, 1988

Dr. William L. Roper
Administrator, Health Care Financing Administration

SUMMARY STATEMENT
National Commission to Prevent Infant Mortality

Medicaid pays for health care for approximately 11 million children in our nation. The Medicaid program is the primary source of health care for the most vulnerable of our children -- those who are poor and disabled.

The Medicaid program is addressing the problem of infant mortality and the high incidence of low birthweight babies at its source -- by increasing access to quality prenatal and maternal health care services for high-risk pregnancies.

For a good part of its history the Medicaid program was linked to the receipt of welfare benefits. Recent Congressional action has removed that link for some groups of recipients. States now have the option of providing Medicaid coverage for pregnant women and for certain children who are not eligible for AFDC because their income exceeds the State standard. These new options extend the possibility of Medicaid to many up to and above the poverty line.

States have made major progress toward improved access to prenatal care by streamlining the Medicaid application process and expanding coverage of women in poverty. Twenty States are covering pregnant women up to 100 percent of the federal poverty line. Another 23 States are considering this optional coverage category. This would mean up to 43 States would be providing coverage to women with incomes at or near $11,650 in a family of four.

The Early and Periodic Screening, Diagnosis and Treatment (EPSDT) program provides an important access point into the health care system for many children. HCFA has mailed a new Medicaid Manual Issuance that should give states clearer directions on EPSDT implementation. Approximately 3 million Medicaid-eligible children received initial or periodic exams in Fiscal Year 1987, with many of them receiving follow-up treatment.

Because Medicaid is a state-operated program, the real story is how states are meeting the challenge of caring for low-income mothers and infants in the face of new diseases, fiscal problems and complex care needs. HCFA is committed to working with the States in meeting these challenges in essential and innovative ways.

Mr. Chairman and Members of the Commission, I am Dr. William L. Roper, Administrator of the Health Care Financing Administration (HCFA), which oversees the nation's Medicare and Medicaid programs.

Medicaid pays for health care for approximately 11 million children in our nation. The Medicaid program is the primary source of health care for the most vulnerable of our children -- those who are poor and disabled -- as well as their mothers.

I am also speaking to you today as a pediatrician, and a former public health officer in the State of Alabama. The problem of infant mortality is therefore one that weighs deeply on me as a government official, as a physician and as a citizen.

The death of an infant is a desperate human tragedy. For a physician, it is a source of agony. And, when it happens so often in a nation that prides itself on the quality of its medical care, it is also a stigma and a shame.

America still suffers from the stigma of being unable to match the infant mortality rate of such industrialized countries as Japan, Canada, Ireland, Switzerland and France. It is true that the infant mortality rate in the United States, about 10 per 1,000 live births, is the lowest in our history, more than 15 percent lower than it was in 1980. But it is also nearly 20 percent above our goal for 1990.

I commend the members of the National Commission to Prevent Infant Mortality for bringing this critical public health problem to the forefront of the nation's health care agenda.

In turn, I am pleased to be able to report to the Commission that the Medicaid program is addressing this problem at its source, by increasing access to quality prenatal and neonatal services.

Today, more than ever, we realize that a healthy start in life requires good prenatal care. Poor prenatal care, and prenatal care begun late in the pregnancy, have been identified as key contributors to the birth of low birthweight babies. These infants are more likely to have significant health problems and are in greater jeopardy of dying.

Therefore, early access to quality prenatal care is a critical issue. Medicaid is responding in three ways:

-Recent legislation has severed the link between Medicaid and welfare, so that more high-risk women can have access to preventive maternal and child care.

-The Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT), is continuing to offer health screening and treatment to Medicaid recipients under age 21, AND

-HCFA has fostered increasing cooperation between the Medicaid program and various other Federal and state agencies.

Because Medicaid is a State-operated program, the real story is how States are meeting the challenge of caring for low-income mothers and infants in the face of new diseases, fiscal problems and complex care needs.

I would like now to discuss Medicaid's initiatives in more detail.

Pregnant Women and Children

For a good part of its history the Medicaid program was linked to the receipt of welfare benefits. Recent Congressional action has removed that link for some groups of recipients.

States now have the option of providing Medicaid coverage for pregnant women and for certain children who are not eligible for AFDC because their income exceeds the State standard. These new options extend the possibility of Medicaid to many up to and above the poverty line.

At the same time, State Medicaid agencies, Maternal & Child Health agencies, Women, Infants, and Children Supplemental Nutrition (WIC) programs, together with health departments and local health clinics, are sharing fiscal and personnel resources to enhance their efforts and expenditures. Such coordination helps provide comprehensive, case-managed care to special populations, such as disabled children and high risk pregnant women.

We at HCFA are encouraging States to increase their cooperative efforts. There is a Maternal and Child Health Technical Assistance Group -- made up of Medicaid and Maternal and Child Health directors, together with HCFA staff -- which meets periodically to foster cooperation between the two programs.

Besides making good sense, improved cooperation leads to improved health care for Medicaid recipients. Together with the recent expansion in eligibility, this cooperation enables State Medicaid agencies to serve more people more effectively.

States have made major progress toward improved access to prenatal care by expanding coverage of women in poverty and streamlining the Medicaid application process.

Twenty States are covering pregnant women with incomes up to 100 percent of the federal poverty line. Another 23 States are considering this optional coverage category. This would mean that up to 43 States could soon be providing coverage to women with incomes at or near $11,650 in a family of four.

Several States are considering the new option provided by the Omnibus Budget Reconciliation Act of 1987, which allows States to cover women up to 185 percent of poverty, or $21,500 for a family of four. There are now indications that as many as 7 States may select this option in the coming year.

Quicker access to prenatal care is being achieved through State adoption of presumptive eligibility. This policy allows a pregnant woman who appears to meet Medicaid eligibility requirements to be covered from the moment she walks into an approved provider's office seeking care.

Under this coverage option, the State guarantees approved providers that it will cover those expenses even if the woman is later determined ineligible after the formal Medicaid application process. Twelve States have adopted this coverage option, and we expect more will once they have developed State policy to approve providers.

The presumptive eligibility option should begin to address the problems of inadequate access to early prenatal care. Assuring that bills will be paid for initial visits reduces the uncertainty among women and providers over payment, thereby increasing the likelihood that the woman will seek care and that the doctor will continue to provide it.

Some States have initiated other programs to simplify the Medicaid application process. Several State agencies have placed Medicaid eligibility workers at major hospitals, clinics, and large providers' offices to complete the Medicaid applications on site when the woman comes in for care. Seventeen States have dropped the assets test for pregnant women. Eliminating this test considerably speeds up processing of the Medicaid application because investigating the assets statement is a lengthy process.

Improvements in prenatal care have been accompanied by expanded Medicaid eligibility for children in poverty. Eleven States have opted to cover children through age 2 in families with incomes up to the poverty line.

As the result of these coverage expansions, an estimated 650,000 additional low-income women and children will be covered by Medicaid at the end of Fiscal Year 1989, and we will be spending approximately $255 million more in Federal dollars.

In addition to expanded eligibility, many States have developed comprehensive prenatal care programs for high risk pregnant women.

Among the innovative programs developed is one in South Carolina which channels these women through a special program providing a full range of prenatal and intra-partum care as well as ancillary services such as social work assessment, nutritional evaluations, and health education. This program is estimated to realize $3.1 million savings through reduced neonatal care and reduced institutionalization of children.

Early and Periodic Screening, Diagnosis and Treatment (EPSDT)

Although recent Medicaid expansions have received a good deal of Congressional attention, we should also give credit to the Early and Periodic Screening, Diagnosis and Treatment program.

This mandatory program, known as EPSDT, provides health screening and treatment to Medicaid recipients under age 21. The basic EPSDT screening and treatment services include: physical examination, developmental assessment, immunizations, nutritional assessment, vision and hearing tests, and some dental services.

The required services of this program are augmented in 24 States with additional child health services. For example, through EPSDT, States can provide pre-pregnancy care and counseling to teenagers or target a specific package of prenatal services to pregnant teens. States may also offer broader services to EPSDT recipients than are otherwise offered under the Medicaid State plan.

Approximately 3 million Medicaid-eligible children received initial or periodic exams in Fiscal Year 1987. EPSDT provides an important access point into the health care system for many children. On March 22, HCFA mailed a new Medicaid Manual Issuance that should give states clearer directions on EPSDT implementation.

I am also pleased to note that the American Academy of Pediatrics has assembled a resource handbook to encourage pediatrician support for the EPSDT program and to promote participation in the program.

Departmental Studies on Improved Health Care

Finally, I would like to note that the Department of Health and Human Services has established a Low Birthweight Prevention Group jointly chaired by the Directors of the Health Resources and Services Administration (HRSA), the Maternal and Child Health Division, and the National Institute on Child Health and Human Development.

HCFA participates actively in this group, which is examining problems associated with pregnancies that result in low birthweight babies, and seeks policies to improve our programs and to decrease low birthweight outcomes in the future.

In summary, then, Mr. Chairman and members of the Commission, I am pleased to report that HCFA -- in partnership with State Medicaid agencies, Maternal and Child Health providers, and State public health officials -- is working to provide quality health care for millions of children in this country in an innovative and cost-effective manner.

And we have every reason to believe our efforts are bearing fruit. In my home State of Alabama, a 1985 study showed infant mortality rates among Medicaid recipients at 9 percent, well below the State average of 12.5 percent. This data supports my belief that enhancing the Medicaid program works.

The majority of States are expanding eligibility standards in order to cover more low-income women and children. The approach taken by many States, with the support and encouragement of the Federal government, demonstrates the kind of commitment we in the Medicaid program have to this critical sector of our society -- our children.

Thank you very much.

STATEMENT OF

JEANNIE I. ROSOFF

PRESIDENT

THE ALAN GUTTMACHER INSTITUTE

BEFORE THE

NATIONAL COMMISSION TO PREVENT INFANT MORTALITY

Chicago, Illinois

April 25, 1988

Statement of Jeannie I. Rosoff, President, The Alan Guttmacher Institute

For 20 years, The Alan Guttmacher Institute has specialized in research and policy analysis on matters relating to reproductive health. The relationship between prenatal care and the reduction in adverse birth outcomes and the link between family planning and improved maternal and child health have both been well documented elsewhere and are only touched upon in this testimony, which addresses the financing of maternity care and the evidence developed by the Institute in a recent major research project. The evidence indicates that financial barriers lead some women to obtain inadequate prenatal care.

Having a baby is costly, especially considering that the $4300 average cost is more than one-fifth of the average annual income of the typical couple needing maternity care. While most women have some private health insurance, not all policies cover maternity care, largely because of loopholes in the federal Pregnancy Discrimination Act. In 1985, 333,000 women having babies had private insurance that did not cover their maternity care. Also, many policies had waiting periods, did not cover all needed services or paid only a portion of the bills. While state laws require coverage of an employee's newborn, they do not require coverage of the newborn of a nonspouse dependent.

Public programs help pay the costs for the delivery of about one-fifth of all new babies; Medicaid alone paid for 17 percent of all births in 1985. Since Medicaid eligibility standards vary from state to state, the proportion of all births covered differs dramatically. Efforts to inform pregnant women about availability of Medicaid benefits were sparse and uneven and the process of applying for Medicaid so cumbersome as to almost preclude entry into prenatal care in the first trimester. Low reimbursement rates are a major factor in physicians' reluctance to participate; in 1986, when physician fees for a regular delivery averaged $830, Medicaid reimbursement averaged only $554. The Maternal and Child Health Block Grant and community and migrant health center programs also play an important role. While these programs do much to increase access to prenatal care, they are of limited usefulness when it comes to paying the hospital bill, which is the bulk of the cost of maternity care.

Fifteen percent of women giving birth, 555,000 women each year, have no insurance coverage, either public or private, for their deliveries. While uninsured women may have access to prenatal care at clinics, they frequently face obstacles to hospital admission for delivery; they are likely to arrive at hospitals as emergency patients and be delivered by physicians they have never met. Maternity and newborn care account for 27 percent of all uncompensated hospital care, the single largest source of unpaid hospital debt.

Although Congress and the states have made much progress, some steps need to be taken immediately. These include assuring maternity and newborn coverage under all private policies, expanding Medicaid eligibility for women without private insurance, improving Medicaid application procedures and outreach, "de-linking" Medicaid applications from the welfare system, improving the link between clinics and hospitals and improving access to family planning. Since fixing all the problems in our current patchwork system would take several years, an alternative approach that should be given careful consideration would be to create an entitlement to maternity and infant services, as we have created an entitlement for care for the elderly through Medicare.

Mr. Chairman and Members of the Commission:

It is a pleasure to appear here today to discuss the Institute's work on the financing of maternity care and to address briefly the relationship between family planning and reductions in infant mortality. By way of introduction, The Alan Guttmacher Institute is a 20 year-old private nonprofit corporation specializing in research and policy analysis on matters relating to human reproduction. Most of the information I plan to share with you today comes from a major two-year research effort undertaken by AGI with support from the Pew Memorial Trust.

There has been considerable speculation over the years about why some women obtain inadequate prenatal care. Is it for cultural or motivational reasons? Because services are not readily available? Or because of insufficient funds or inadequate financing systems? Research emanating from many sources indicated that financing of care was a real problem for individual women as well as institutions. Maternity care had been shown to constitute a large share of uncompensated hospital care and anecdotal evidence indicated that some hospitals were "dumping" pregnant women in an effort to avoid admitting non-paying patients. Knowing that financial problems could be relatively easily rectified through appropriate policies and programs, whereas efforts to motivate individual women would be far more complicated, we decided to undertake a detailed examination of how maternity care is financed in the United States and to document any problems we identified.

The Institute analyzed most major national data tapes that contained information about utilization of maternity services, payment for services and health insurance coverage (e.g. National Natality Survey, National Hospital Discharge Survey, Level of Benefits Survey, Current Population Survey, etc.). In addition, it conducted seven original surveys of state Medicaid directors, state Maternal and Child Health directors, community and migrant health centers, the 100 largest private insurance companies, all Blue Cross/Blue Shield plans and state attorneys general (to determine state laws and regulations concerning insurance coverage of maternity care). The results of this research are reported in Blessed Events and the Bottom Line: Financing Maternity Care in the United States and in a lengthy volume of background reports.

PRENATAL CARE, FAMILY PLANNING AND INFANT MORTALITY

The relationship between prenatal care and the reduction of infant mortality and other adverse birth outcomes has been documented by a number of experts and prestigious bodies, most notably by the Institute of Medicine in its report, Preventing Low Birthweight. Our own work buttresses that body of research:

- The infant mortality rate is 9.7 per 1,000 live births among newborns whose mothers began prenatal care in the fist trimester; it rises to 12.5 per 1,000 when care was initiated later in pregnancy; and it jumps to 48.7 per 1,000 when the mother obtained no prenatal care at all.
- Women who obtain insufficient prenatal care are twice as likely as those who have sufficient care to have a low birthweight baby (10 percent versus 5 percent);

- Women with insufficient care are also more likely to have their baby prematurely (13 percent versus eight percent);

The Commission may be less familiar with the body of evidence on the link between family planning and maternal and child health. However, that too has been clearly documented:

- In 1981, the congressionally-mandated Select Panel for the Promotion of Child Health reported, "A voluminous body of research indicates the timing of a birth (when the mother is neither too young nor too old), adequate intervals between births, and family size limitations are closely related to better maternal and infant health. Infant mortality, low birthweight and stillbirths can be reduced through family planning."
- A 1981 study of the roles of public policies and programs in reducing infant mortality found that increased use of family planning services by low income women between 1964 and 1977 was the largest factor (after the legalization of abortion) contributing to declining neonatal mortality.
- The Institute of Medicine in its 1985 report, Preventing Low Birthweight, concluded that "family planning services should be an integral part of overall strategies to reduce the incidence of low birthweight in infants."

While we cannot prove that women who have difficulty in paying for health care also obtain inadequate prenatal care, the evidence points clearly in that direction. Fully a third of pregnant women get insufficient prenatal care and the groups of women most likely to be uninsured -- those living below the poverty level, minorities, the unemployed and unmarried women -- are also those most likely to have obtained inadequate prenatal care or no care. The proportion of uninsured women who obtain only late prenatal care is twice the national average, and the proportion of uninsured women who obtain no prenatal care is about four times the national average. A recent report by the General Accounting Office, based on interviews with over a thousand new mothers, found that nearly two-thirds of Medicaid recipients and uninsured women had received insufficient prenatal care. Lack of financial resources was the reason most cited.

THE COST OF HAVING A BABY

Having a baby is a costly proposition. The average bill in 1985 was $4,300. Even an uncomplicated pregnancy cost about $2,900 -- with 60 percent of that going for the hospital -- and, of course, the cost goes up as complications occur. Thus, a cesarean birth cost $4,900, on the average, when there were no health problems with the newborn, and the bill can run to many thousands of dollars if the infant goes to neonatal intensive care.

These costs are particularly devastating when it is kept in mind that most births are to couples who are young and are often employed in entry-level positions, many of them without health insurance benefits. Almost half of all births are to women with incomes below 200 percent of poverty; almost 40 percent are to women who are unemployed or in part-time positions; and over 40 percent are to women under age 25.

The average cost of having a baby is more than one-fifth of the average pre-tax income of a typical couple in their early twenties where both persons work. Moreover, four out of 10 births are unintended so that women and families do not have the opportunity to accumulate savings or ensure that they have adequate health insurance coverage.

FINANCING SYSTEMS

Since the cost of having a baby is so high relative to the average income of young couples, most families rely on some form of insurance to finance maternity care. Seventy-three percent of women of reproductive age have some form of private health insurance; 67 percent have employment-related insurance, and an additional six percent have so-called nongroup coverage, policies that are unrelated to employment. Ten percent have some form of public health insurance, usually Medicaid.

Public Programs

Public programs help pay for medical care for about one in five new mothers. The largest of these programs, Medicaid, paid for 17 percent of all births (630,000) in 1985 but because eligibility standards for Medicaid vary so dramatically from state to state, the proportion of all births covered by the program differs drastically. In 1985, it ranged from three percent in Alaska to 25 percent in Michigan. In any event, only a fraction of the poor (i.e., persons with incomes below the federal poverty level) are eligible for Medicaid-subsidized care. In 1986, the income ceiling for Medicaid eligibility averaged 56 percent of poverty across the states, ranging from 16 percent in Alabama to 109 percent in California.

Some of these state-to-state differences in access to Medicaid-funded maternity care are being removed as some states opt to expand Medicaid for pregnant women with incomes up to the federal poverty level. According to the National Governors' Association, 35 states have opted to cover pregnant women with incomes above usual Medicaid eligibility levels. We hope that states will respond as enthusiastically to the option to cover women up to 185 percent of poverty -- but we fear they may not. Until the federal government mandates coverage of pregnant women up to certain income levels, these state-to-state inequities will persist.

It is important, too, that efforts to expand Medicaid coverage be accompanied by efforts to improve the actual operation of the program. Because Medicaid is generally administered by the welfare bureaucracy, it is not surprising that many states concentrate more on keeping ineligible applicants out of the system than on reaching out to make sure all those who qualify are included. Our survey of state Medicaid agencies in 1986/87 found that efforts to inform pregnant women about the availability of Medicaid benefits were sparse and uneven. Indications are that states are stepping up their outreach efforts as they begin to implement the Medicaid expansion, but unless they launch major outreach campaigns, the promise of an expanded Medicaid program will not be fulfilled.

The process of applying for Medicaid is so slow and cumbersome as to almost preclude entry into prenatal care in the first trimester of pregnancy. Once a woman finds out she is pregnant and decides to apply for Medicaid, she must fill out an application form that rivals -- and sometimes exceeds -- the IRS forms in complexity. These forms average 14 pages in length across the states, but can run to as many as 40 pages; completing an application, together with the required documentation, usually entails several visits to the welfare office. Once the application is completed, it usually takes about a month for the state to determine whether an individual is eligible; in many states it takes longer. Steps taken by Congress last year to encourage simpler applications for pregnant women by waiving questions about resources, and to enable providers to claim reimbursement for services provided to pregnant women who they expect to be eligible for Medicaid -- so-called "presumptive eligibility" -- are important, but they are being implemented in only a minority of states.

Another critical issue that needs to be addressed is that of physician participation in Medicaid. Forty-four percent of physicians providing obstetric services will not accept Medicaid payments for delivery, with the predictable result that Medicaid patients are far more likely to get care from clinics then their more affluent counterparts. (Sixty percent of women whose delivery is subsidized by Medicaid obtain prenatal care at a clinic, compared with just 21 percent of all women.) One of the most important factors in physicians' reluctance to participate in Medicaid is low reimbursement. In 1986, physician fees for a regular delivery averaged $830 but Medicaid reimbursement averaged only $554. In New Hampshire, Medicaid paid only $216, while in neighboring Massachusetts the payment was $1,027. Even if reimbursement rates were raised in all the states, the bureaucratic red tape involved in dealing with Medicaid will still deter many providers from participating.

If Medicaid is to be made to work well for pregnant women who are not on AFDC, the program's availability must be widely known, the stigma associated with receipt of Medicaid or welfare benefits must be removed, the application process must be quick and easy and participation by providers must be broadened by making it attractive.

Public programs other than Medicaid also play an important role in providing access to maternity care, particularly by supporting a network of clinics to which women can go for services. Two of the largest of these programs are the Maternal and Child Health Block Grant (Title V, Social Security Act) and the community and migrant health center programs (Secs. 329 and 330, Public Health Service Act). While these programs provide a range of primary care services to women and others, in 1986 they provided prenatal care to an estimated 660,000 women (447,000 in MCH clinics and 213,000 in community and migrant health centers). These clinics were a major access point for prenatal care for Medicaid patients and the uninsured: a third of these patients were covered by Medicaid and almost six out of 10 were uninsured.

Since the MCH Block Grant, like Medicaid, is administered by the states, eligibility varies widely, from 100 percent of poverty to 300 percent or higher. There is no clear pattern, however, which would show that MCH Block

Grant funds are being used to iron out state-to-state differences in coverage under Medicaid. Moreover, not all states choose to use their MCH block grant funds for prenatal care: Alaska, Montana, North Dakota and Wyoming do not. In addition, four of the states that do provide prenatal care serve only high-risk patients (Hawaii, Idaho, Minnesota and South Dakota) and two serve only low-risk patients (Louisiana and Virginia).

Although community and migrant health centers are federally-administered, so that there are not the drastic differences in eligibility that are seen in state-administered programs, these centers also do not cater to all those in need. There are no such centers in Wyoming and, where there are centers, they do not always offer prenatal care. Fifteen percent do not provide such care, many serve only a limited number of patients, and a third of those that do provide prenatal care limit services to low-risk women.

Clearly these two programs do much to provide access to prenatal care, but they are of very limited assistance when it comes to the hospital bill for delivery -- which accounts for the bulk of the cost of maternity care. Only six percent of women who got prenatal care from MCH Block Grant-supported clinics and three or four percent of those who got care from community or migrant health centers received help with the hospital bill -- and even then the contribution was usually modest. In fact, clinics often provided little or no assistance to women seeking to plan for hospital admission for delivery.

Private Health Insurance

Traditionally, private health insurance has been regulated largely at the state level. States, however, do not have authority over all private health insurance policies. State insurance laws do not apply to the insurance coverage that is offered by employers who self-insure by organizing their own health-benefit plans for their employees. Self-insurance is more common among large employers; more than 40 percent of workers who are insured through medium and large companies are covered by these self-insured plans.

Since maternity care historically was viewed by insurance companies as preventive rather than curative, many private health insurance plans excluded coverage of maternity care. In 1978 Congress enacted the Pregnancy Discrimination Act (PDA) that requires most employers to cover pregnancy-related services in the same way as other medical services are covered. (Since the PDA is a federal and not a state law, it applies to self-insured employers.) While the effects of the PDA in extending coverage of maternity care have been dramatic, the law unfortunately does not guarantee that all women who have private health insurance coverage are covered for maternity care.

The PDA has several important loopholes. First, it does not apply to the three million women of reproductive age who have nongroup policies. Second, the law only guarantees coverage to the employee and the employee's spouse, and not to a nonspouse dependent such as a teenage daughter. Third, the PDA does not apply to firms that employ 15 or fewer workers. Largely as a result of these three loopholes, about nine percent of women of reproductive age--some five million women--have private health insurance policies that do not cover maternity care. Each year, approximately 333,000 women who have babies have private insurance coverage that does not cover their maternity care.

All states require that newborns be covered under their parents' insurance policies from the moment of birth. While these state laws are not directly applicable to self-insured employers, these laws set a standard for almost all employers, even if they self-insure. Several states have additional requirements. Eleven states specifically require coverage for premature infants and six states require that policies cover transportation of a newborn to an acute care facility when necessary.

State laws concerning newborn coverage have two important drawbacks that can preclude needed coverage in some cases. First, the laws generally apply to coverage of illness, but not to in-hospital well-baby care (which may extend to several days if the mother has had a cesarean delivery or other complications of childbirth). While five states have laws or policies specifying that necessary well-baby care be covered, six specifically exclude coverage of well-baby care, although policies are free to include such coverage voluntarily. Half of typical group policies do not cover routine physician care of newborns in the hospital.

The second problem with the state laws is at the intersection of federal and state policy. The federal PDA does not require that the pregnancy of a nonspouse dependent be covered, and state newborn laws--since they apply only to newborn infants of employees and their spouses--do not require coverage of the newborns born to nonspouse dependents. Consequently, only 25 percent of typical private insurance policies cover both the pregnancy of a teenage daughter and the care needed by her newborn baby.

Private health insurance has other shortcomings as a financing mechanism for maternity care. Most insured women are in policies that require either a waiting period before coverage can begin or before pre-existing medial conditions, such as pregnancy, are covered. Only a fraction of insurance policies pay for the full cost of the care that is needed by a pregnanct woman; more than nine in ten insurance plan participants have coverage that is limited by deductibles, copayments or maximum insurance payments. In addition, plans do not always cover all necessary care. For example, 14 percent of typical policies do not cover rho-gam injections for a pregnant woman. Taken together, these problems can result in some women failing to get sufficient and timely care and in serious financial hardship for some families.

Women Without Insurance Coverage For Maternity Care

As has been mentioned above, some women with private health insurance may find that their coverage excludes their maternity care. Some, but not all, women who had no insurance protection before becoming pregnant may find themselves eligible for Medicaid once pregnant. At the time of delivery, 15 percent of women have no public or private health insurance; each year, 555,000 women give birth with no insurance coverage for their maternity care. Teenage mothers and those in their early twenties are most likely to lack insurance coverage for delivery.

This fact has serious ramifications for us as a society, the women and families involved and our providers of medical care. As has been mentioned above, uninsured women are more likely than insured women to obtain sufficient prenatal care. They are also more likely to face obstacles to hospital admission at the time of delivery. Women who have no insurance may be asked to pay a pre-admission deposit of between $500 and $1000 in order to obtain hospital care. In the past, some private hospitals were reported to have refused to admit uninsured patients. In 1986, a federal law took the first step toward ending this practice by prohibiting hospitals from "dumping" uninsured women who are in "active labor." Unfortunately, the law does nothing to prevent hospitals from refusing care to women who are in the early stages of labor or who have complications during pregnancy.

The fact that so many women having babies have no insurance for their maternity care also has grave implications for medical providers who are affected by the complexity of arranging and financing the services needed by their patients. Further, while some pregnant women may forego prenatal care in the absence of insurance, almost all deliver in hospitals. Maternity and newborn care account for 27 percent of all uncompensated hospital care in the United States. Since there is no orderly third-party payment system for this care, the cost is being shifted, in a disorganized and haphazard way, to federal, state and local governments, insurance companies and Blue Cross/Blue Shield plans, employers who insure their employees and, ultimately, employees and taxpayers. In short, this care is being delivered, and we are all paying the bill.

CONCLUSION

This country has a patchwork system of financing maternity care. Although Congress and the states have made much progress in the past decade toward improving access to maternal and child health services, much remains to be done. Some of the immediate steps that need to be taken include:

- Requiring coverage for maternity care of all women insured under private policies and coverage of all newborns from the moment of birth;
- Gradually expanding Medicaid to cover maternity and newborn care for those who cannot purchase private insurance with premiums graduated on the basis of a family's ability to pay;
- Requiring states, or providing financial incentives to them, to make aggressive efforts to inform poor women about the availability of Medicaid subsidy for maternity care; to process Medicaid applications in a reasonable period of time; and to offer providers reasonable reimbursement for maternity and newborn care;

- Establishing state systems not linked with the welfare system to handle Medicaid applications;
- Strengthening community-based clinic services and improve their connections with hospitals for delivery, to assure continuity of care; and
- Improving access to family planning services, particularly for low- and marginal income women and teenagers, to reduce the incidence of unplanned pregnancy.

If all of these recommendations were adopted throughout the country, and fully implemented, the current system could be made to work much better than it now does. Realistically, however, it will be many years until they are adopted by Congress and all the states -- and that day many never come.

If, therefore, our goal is to make certain that all women have access to at least basic maternity and infant care, an alternative approach would be to create an entitlement to these services, in much the same way as we have created an entitlement to health care for the elderly through Medicare. Such a system would be less cumbersome and expensive to administer than the many different systems currently employed. It would eliminate the state-by-state variations in eligibility and benefits inherent in the Medicaid program, and also circumvent the stigma attached to programs designed and administered with only welfare clients in mind. Most of the expenses of maternity and infant care are already being paid by somebody -- if not by private insurance or Medicaid, then eventually by the public, through inflated premiums, taxes or charity. The only "new" expenses of a nationwide system would be for early prenatal care. However, these expenditures are relatively small and would undoubtedly save money in the long run by improving the health of new mothers and newborns. Such a universal system could be financed through a combination of public and private revenues and be administered under the auspices of the federal government, as are Medicare and Social Security. It would provide a basic, uniform benefit package with built-in cost control provisions, and would cover all pregnant women and their babies, regardless of family income.

Adequate and effective financing would not solve all the problems of ensuring access to care, neither would it be reflected in an immediate decline in infant mortality -- but it would help considerably. We believe it is unconscionable that we as a society appear to care so little for the next generation that we cause couples to hesitate about having a baby for fear they cannot afford proper medical care, and place obstacles in the way of pregnant women who seek and need such care.

Testimony of

Senator Robert C. Scott

National Commission to Prevent Infant Mortality

Chicago, Illinois
April 25, 1988

Thank you for the opportunity to testify today. The fight against infant mortality has been an elusive fight at the state level. I have been involved in that fight for approximately ten years, beginning with a bill to remove the Commonwealth of Virginia from the list of six states that did not provide prenatal care under the medicaid program to women having their first baby. When this bill was suggested to me, I discovered one of the shortcomings of being a state legislator: State legislators do not have research staffs. Fortunately, the evidence of the cost effectiveness of prenatal care was easy to find.

So there I was, a first term delegate, with a one million dollar budget amendment, with no apparent constituency in support, assuming that facts, figures, logic and a little compassion were sufficient for persuasion. I learned... For three years, the bill was defeated. It was only after we received help from one Dr. Rae Grad, then president of the Virginia Perinatal Association; Dr. Fred Wirth, a neotatalogist in Norfolk; The March of Dimes, and the Children's Defense Fund, and a gentle push from Governor and Mrs. Robb that Virginia was eventually removed from that list of dubious distinction.

In the following years, we passed legislation which provided for the reporting of birth defects as a vital statistic and the testing and screening of infants for problems that require early intervention. We also increased fees for obstetricians; established several Resource Mothers programs to assist low-income teenagers, and created a two year

Infant Mortality Council of administrators and lay members.

We also established, under the Secretary of Human Resources, a Council on Prevention. Bureaucrats will often publically support prevention programs, but they will quietly sabotage the idea as soon as they merely suspect that their agency may lose staff or funds as a result.

During the discussions of SOBRA last year, we heard as much about the impact on various agency budgets as we heard support for the proposal. This year, after receiving numerous recommendations, and intense lobbying, the SOBRA amendment was introduced as part of the Governor's Budget and adopted at 100%. The legislature added funds for case coordination and enhanced services.

Next year's fights on the state level in Virginia will include addressing indigent health care generally; allocating state funds to WIC; coordinating our resources; and increasing early intervention services for developmentally disabled infants.

On the state level, it is difficult to maintain the political pressure that's required to make frequent multi-million adjustments in the budget, primarily because the beneficiaries are without political clout. Therefore, without firm guidance from the federal government, the health care of American children across the nation will be subject to annual last minute, late night compromises and legislative deal-making.

I would therefore hope the committee will consider, among other suggestions, the following:

1) SOBRA Medicaid option increased to 185% of poverty and mandatory at 100%.
2) Increased funds for WIC: We are now reaching 1/2 of the eligible population.
3) More obstetricians. In many areas of Virginia, access is a problem irrespective of ability to pay. Medical scholarships, assistance to OB residency programs and National Health Service placements will help.
4) Outreach and support services. Significant improvement in outcome occurs when there are nurses and Resource Mothers who have the time to support, educate, counsel and visit patients during their pregnancy and after birth. The public health clinic in my district has achieved a low birth weight rate of 4.7% and a rate of 3.8% for those who began in the first trimester and had at least 10 prenatal care visits. Our Resource Mothers program has experienced a 7.5% low birth weight rate - and that's for low income, minority teenagers, the highest risk group of all.

Thank you for the opportunity to be with you today. I look forward to your recommendations and the health of children of the future will benefit by your deliberations.

TESTIMONY OF DAVID N. SUNDWALL, ADMINISTRATOR
HEALTH RESOURCES AND SERVICES ADMINISTRATION

ON BEHALF OF

DR. ROBERT WINDOM, ASSISTANT SECRETARY FOR HEALTH
U.S. PUBLIC HEALTH SERVICE

FOR DELIVERY AT THE NATIONAL COMMISSION TO PREVENT INFANT MORTALITY FOURTH NATIONAL HEARING, "THE ROLE OF GOVERNMENT IN REDUCING INFANT MORTALITY" - APRIL 25, 1988, STATE OF ILLINOIS CENTER, CHICAGO, ILLINOIS

I APPRECIATE THIS OPPORTUNITY TO TESTIFY FOR THE PUBLIC HEALTH SERVICE ON BEHALF OF THE ASSISTANT SECRETARY FOR HEALTH, DR. ROBERT WINDOM. HERE WITH ME IS DR. VINCE HUTCHINS OF THE BUREAU OF MATERNAL AND CHILD HEALTH AND RESOURCES DEVELOPMENT.

HAVING ATTENDED THE PAST MEETINGS OF THE COMMISSION AS DR. BOWEN'S REPRESENTATIVE, I AM FULLY AWARE OF YOUR INTEREST IN REDUCING THE INCIDENCE OF INFANT MORTALITY IN THIS COUNTRY AND HOW YOUR EFFORTS ARE IMPORTANT TO OUR NATIONAL COMMITMENT. I'M PLEASED TO PLAY A ROLE IN THIS WORK.

AS A FAMILY PRACTITIONER I AM SENSITIVE TO THE CLINICAL AND HUMAN ASPECTS OF THE PROBLEM.

BEFORE I CAME TO MY PRESENT ASSIGNMENT, I WORKED FOR SENATOR ORRIN HATCH AS HEALTH STAFF DIRECTOR AND PHYSICIAN ADVISOR TO THE SENATE COMMITTEE ON LABOR AND HUMAN RESOURCES. THAT EXPERIENCE AND MY CURRENT RESPONSIBILITY IN THE HEALTH RESOURCES AND SERVICES ADMINISTRATION HAVE ENABLED ME TO SEE THE PROBLEM FROM THE FEDERAL VIEWPOINT.

INFANT MORTALITY IS A NATIONAL CONCERN AND REMAINS A TOP PRIORITY FOR THE FEDERAL GOVERNMENT. SECRETARY BOWEN HAS JUST FINISHED OUTLINING THE CURRENT STATUS. AND HE POINTED OUT THAT WE'RE DOING BETTER, BUT CERTAINLY NOT AS WELL AS WE SHOULD.

THE FIRST FEDERAL STUDY ON INFANT MORTALITY WAS CONDUCTED BY THE CHILDREN'S BUREAU IN 1913. THE REPORT ENUMERATED MANY OF THE CONCERNS THAT ARE CENTRAL TO TODAY'S EFFORTS. IT RECOGNIZED THAT BARRIERS EXISTED IN ACCESS TO GOOD PRENATAL AND INFANT CARE, THAT THERE WAS A SHORTAGE OF FACILITIES PROVIDING PRENATAL AND INFANT CARE, AND THAT FACTORS LIKE BREASTFEEDING AND PARENT EDUCATION PLAYED A SIGNIFICANT ROLE IN INFANT HEALTH.

THE CURRENT FEDERAL ROLE IN INFANT MORTALITY EVOLVED FROM THAT EARLY WORK OF THE CHILDREN'S BUREAU. TODAY, THE PUBLIC HEALTH SERVICE HAS PRIMARY RESPONSIBILITY FOR FEDERAL LEADERSHIP IN THE NATIONAL EFFORT. WE SEE OUR PRESENT ROLE, HOWEVER, AS ENCOMPASSING MORE THAN THE REDUCTION OF INFANT MORTALITY. IT'S THE PREVENTION OF LOW BIRTHWEIGHT, THE REDUCTION OF ACCIDENTS AND INFECTIOUS DISEASES IN INFANTS, AND THE PROMOTION OF OPTIMAL GROWTH AND DEVELOPMENT IN HEALTHY NEWBORNS.

WHAT WE'RE DOING IN THE PUBLIC HEALTH SERVICE TO MEET THESE EXPANDED OBJECTIVES EMBODIED IN THE SURGEON GENERAL'S OBJECTIVES FOR THE NATION AND HOW WE'RE DOING IT IS WHAT I'D LIKE TO FOCUS ON.

WE APPROACH THE PROBLEM FROM THREE DIRECTIONS.............

RESEARCH

.......BEGINNING WITH RESEARCH. TO EXPAND OUR KNOWLEDGE AND EXPERTISE, THE PUBLIC HEALTH SERVICE SUPPORTS BASIC AND APPLIED RESEARCH AND DEMONSTRATIONS TO ASSESS INTERVENTIONS AND PROGRAMS DESIGNED TO IMPROVE THE HEALTH OF PREGNANT WOMEN AND INFANTS.

WE NEED TO KNOW OUR ENEMY --- THE EXTENT OF THE PROBLEM THAT DR. BOWEN HAS TALKED ABOUT. WE ALSO NEED ACCURATE DATA ON THE VARIABLES RELATED TO INFANT MORTALITY SUCH AS INCOME LEVEL, AGE, RACE, AND GEOGRAPHIC DISTRIBUTION, AND WE NEED TO KNOW HOW THESE FACTORS IMPACT ON LOW BIRTH WEIGHT AND INFANT MORTALITY.

THAT'S ONE TYPE OF THE RESEARCH WE'RE INVOLVED IN. ANOTHER DEALS WITH THE BIOLOGICAL CAUSES AND CURES.

WITH THESE CONCERNS IN MIND, THE AGENCIES OF THE PUBLIC HEALTH SERVICE ARE SUPPORTING A VARIETY OF RESEARCH INITIATIVES. FOR EXAMPLE:

O THE NATIONAL ACADEMY OF SCIENCES IS CONDUCTING A 3 YEAR STUDY TO DOCUMENT AND EVALUATE THE CURRENT SCIENTIFIC DATA ON DIETARY INTAKE AND NUTRITIONAL STATUS OF WOMEN PRE-PREGNANCY, DURING PREGNANCY AND LACTATION --- AND WILL BE MAKING RECOMMENDATIONS FOR PRACTICAL APPLICATION OF THEIR FINDINGS.

O ANOTHER STUDY CURRENTLY UNDERWAY WILL DEMONSTRATE SUCCESSFUL METHODS OF IMPLEMENTING SMOKING CESSATION PROGRAMS FOR PREGNANT WOMEN IN PUBLIC HEALTH SETTINGS.

O NEW INFORMATION ON THE HEALTH STATUS AND HEALTH RELATED BEHAVIORS OF PREGNANT WOMEN AND INFANTS IS BEING COLLECTED THROUGH THE PREGNANCY RISK ASSESSMENT MONITORING SYSTEM.

O AND THE EXPERT PANEL ON THE CONTENT OF PRENATAL CARE IS EXAMINING THE EFFECTIVENESS OF THE VARIOUS COMPONENTS OF PRENATAL CARE AND WILL PRESENT FINDINGS AND MAKE RECOMMENDATIONS FOR FUTURE RESEARCH.

WE'RE PLANNING TO SHARE WHAT OUR KNOWLEDGE AND EXPERTISE WITH REPRESENTATIVES FROM OTHER COUNTRIES AT AN INTERNATIONAL CONFERENCE WE'RE HOSTING NEXT MONTH ENTITLED "ADVANCES IN THE PREVENTION OF LOW BIRTHWEIGHT". WE HOPE TO DIRECT THE ATTENTION OF CONFERENCE PARTICIPANTS TOWARD APPLICATION OF NEW RESEARCH FINDINGS AND TO ENCOURAGE THEM TO MOVE FORWARD WITH THIS KNOWLEDGE TO IMPROVE INFANT OUTCOMES.

SERVICE DELIVERY

THE SECOND AREA IN WHICH THE PUBLIC HEALTH SERVICE HAS RESPONSIBILITY IS ENHANCING SERVICE DELIVERY. WE'VE INITIATED SEVERAL PROJECTS THAT PROVIDE ADDITIONAL RESOURCES, CONSULTATION

AND TECHNICAL ASSISTANCE TO STATES AND LOCAL COMMUNITIES FOCUSED UPON CARE COORDINATION AND INFANT MORTALITY REVIEW.

THESE PROJECTS ARE DESIGNED TO HELP STRENGTHEN THE ORGANIZATION OF SERVICES AND TO FACILITATE THE IMPLEMENTATION OF MECHANISMS --- FINANCIAL AND OTHERWISE --- THAT PROMOTE ACCESS TO CARE.

O WE'RE IN THE PROCESS OF IMPLEMENTING SECRETARY BOWEN'S INFANT MORTALITY INITIATIVE. COMMUNITY AND MIGRANT HEALTH CENTERS WILL SERVE AS VEHICLES FOR PROVIDING CASE-MANAGED, COMPREHENSIVE SERVICES TO LOW-INCOME PREGNANT WOMEN AND THEIR INFANTS THROUGH THE FIRST YEAR OF LIFE.

O WE'RE ALSO COLLABORATING WITH THE ROBERT WOOD JOHNSON FOUNDATION ON A INITIATIVE ENTITLED "HEALTHY GENERATIONS". THIS PROGRAM SUPPORTS NEW SYSTEM-WIDE EFFORTS TO IMPROVE PERINATAL AND INFANT CARE IN GEOGRAPHIC REGIONS WHERE INFANT MORTALITY AND LOW BIRTH WEIGHT ARE PERSISTENT PROBLEMS.

O ANOTHER INITIATIVE, OUR COOPERATIVE AGREEMENT WITH THE NATIONAL GOVERNORS' ASSOCIATION, HAS TWO PRIMARY OBJECTIVES. FIRST, IT'S DESIGNED TO EXPLORE AND PROMOTE BEST PRACTICES; AND SECOND IT PROVIDES TECHNICAL ASSISTANCE TO STATES THAT ARE INTERESTED IN PARTICIPATING IN THE EXPANDED MEDICAID ELIGIBILITY AND COVERAGE OPTIONS RECENTLY AUTHORIZED BY CONGRESS.

THE DESIGN OF EACH OF THESE PROGRAMS REFLECTS A CONSCIOUS ATTEMPT TO STRENGTHEN THE FEDERAL/STATE PARTNERSHIP AND TO PROMOTE THE ACTUAL IMPLEMENTATION OF PROVEN STRATEGIES OVER A LARGE AREA FOR POPULATIONS IN NEED.

FOR SEVERAL YEARS NOW, THE INDIAN HEALTH SERVICE, AN OLD ORGANIZATION BUT A NEW AGENCY IN THE PUBLIC HEALTH SERVICE, HAS AGGRESSIVELY IMPLEMENTED COORDINATED CARE MANGAGED PRIMARY CARE SERVICES IN THEIR SERVICE DELIVERY PROGRAMS. THEY'VE SUCCEEDED IN SUBSTANTIALLY REDUCING THE INCIDENCE OF INFANT MORTALITY IN NATIVE AMERICAN AND ALASKA NATIVE POPULATIONS. THEIR INFANT MORTALITY RATE IS NOW LOWER THAN THOSE FOR MOST OTHER NON-WHITE SUBGROUPS.

COOPERATION

THE THIRD AREA WHERE THE PUBLIC HEALTH SERVICE IS EXERCISING LEADERSHIP IS IN ENCOURAGING COOPERATION AND COLLABORATION AMONG VARIOUS ENTITIES IN THE PUBLIC AND PRIVATE SECTORS.

MANY AGENCIES OF THE FEDERAL GOVERNMENT, STATE AND LOCAL GOVERNMENTS AND MANY PRIVATE ORGANIZATIONS SUPPORT PROGRAMS THAT ARE DESIGNED TO REDUCE THE INCIDENCE OF INFANT MORTALITY. BUT THE CHALLENGES WE FACE ARE FAR GREATER THAN ANY ONE ORGANIZATION OR ANY ONE SEGMENT OF SOCIETY. JUST AS MOST OF THE SUCCESSES

WE'VE HAD IN THE PAST HAVE COME THROUGH COOPERATIVE EFFORTS, THE PROGRESS WE HOPE FOR IN THE FUTURE IS ONLY LIKELY TO MATERIALIZE IF WE POOL OUR KNOWLEDGE, RESOURCES AND SKILLS.

PRACTICALLY EVERY FEDERAL ACTIVITY WE HAVE UNDERWAY DEMANDS EFFECTIVE COMMUNICATION AND COOPERATION OR COLLABORATION, EITHER WITHIN THE AGENCY, BETWEEN AGENCIES OR AMONG THE VARIOUS AGENCIES IN THE HEALTH COMMUNITY.

THIS IS ESPECIALLY TRUE OF THE LARGE AND COMPLEX AGENCIES IN THE FEDERAL GOVERNMENT. WE RECOGNIZE THE IMPORTANCE OF WORKING WITHIN THE FEDERAL GOVERNMENT TO STRENGTHEN AND COORDINATE OUR OWN ACTIVITIES. IN ADDITION TO THE LOW BIRTHWEIGHT PREVENTION WORK GROUP CITED BY DR. BOWEN, WE'VE FORMED MCH ALLIANCES BOTH WITHIN THE DEPARTMENT OF HEALTH AND HUMAN SERVICES AND BETWEEN DEPARTMENTS IN THE FEDERAL GOVERNMENT. FOR EXAMPLE:

O REPRESENTATIVES FROM THE SPECIAL SUPPLEMENTAL FOOD PROGRAM FOR WOMEN, INFANTS AND CHILDREN, BETTER KNOWN AS THE WIC PROGRAM IN THE USDA, AND THE OFFICE OF MATERNAL AND CHILD HEALTH PROGRAM MEET REGULARLY. THEY'VE DEVELOPED FORMAL LINKAGES THAT PROMOTE COMMUNICATION AND COLLABORATION BETWEEN THESE TWO IMPORTANT FEDERAL PROGRAMS.

O THE PRIMARY CARE SERVICES DIVISION OF THE BUREAU OF HEALTH CARE DELIVERY AND ASSISTANCE , THE OFFICE THAT ADMINISTERS

COMMUNITY AND MIGRANT HEALTH CENTERS, AND THE OFFICE OF MATERNAL AND CHILD HEALTH HAVE DEVELOPED A FORMAL LIAISON TO FOSTER COMMUNICATION AND THE SHARING OF EXPERTISE. THESE OFFICES HAVE WORKED TOGETHER IN THE PAST ON SPECIAL PERINATAL AND INFANT MORTALITY INITIATIVES AND WILL CONTINUE THAT COOPERATION TO FACILITATE THEIR COMMON OBJECTIVES.

O THE OFFICE OF MATERNAL AND CHILD HEALTH WORKS COLLABORATIVELY WITH THE OFFICE OF SPECIAL EDUCATION AND REHABILITATIVE SERVICES IN THE DEPARTMENT OF EDUCATION TO ENUSRE SUCCESSFUL IMPLEMENTATION OF PUBLIC LAW 99-457, THE EDUCATION FOR THE HANDICAPPED ACT, WHICH WILL PROVIDE COMPREHENSIVE SERVICES TO INFANTS AND TODDLERS AT RISK AND THEIR FAMILIES.

O THE OFFICE OF MATERNAL AND CHILD HEALTH IS ALSO WORKING WITH THE CENTERS FOR DISEASE CONTROL TO IMPLEMENT A PROGRAM TO PLACE MCH EPIDMIOLOGISTS IN STATES TO IMPROVE DATA COLLECTION AND ANALYSIS CAPABILITIES AT THE STATE LEVEL.

IN ADDITION TO WORKING WITHIN THE GOVERNMENT, THE PUBLIC HEALTH SERVICE ALSO FOSTERS COMMUNICATION AND WORKING RELATIONSHIPS BETWEEN AND AMONG STATES AND THE FEDERAL GOVERNMENT THROUGH ORGANIZATIONS LIKE THE ASSOCIATION OF MATERNAL AND CHILD HEALTH PROGRAMS AND GROUPS LIKE THE STATE MATERNAL AND CHILD HEALTH AND MEDICAID DIRECTORS TECHNICAL ADVISORY GROUP.

AN ADVISORY COMMITTEE MADE UP OF STATE MATERNAL AND CHILD HEALTH PROGRAM DIRECTORS HELPED IN DEVELOPING MOST OF THE ACTIVITIES I'VE DISCUSSED TODAY.

WE'RE ALSO SOLICITING EXPERTISE FROM THE PRIVATE SECTOR ---FROM PROFESSIONALS IN THE HEALTH AND SOCIAL SERVICES (E.G. AAP, ACOG, AAFP, NPA, ASTHO, SGA) WHO FACE ON A DAILY BASIS EMERGING AS WELL AS AGE-OLD CHALLENGES IN MATERNAL AND INFANT HEALTH.

OTHER MORE INFORMAL ASSOCIATIONS (E.G. MEDICAL SCHOOLS, NURSING SCHOOLS, SCHOOLS OF PUBLIC HEALTH, LAY GROUPS, COMMUNITY GROUPS, CIVIC GROUPS) HAVE STRENGTHENED OUR RESPONSIVENESS TO THE NEEDS OF MOTHERS AND INFANTS IN THE CONTEXT OF THEIR COMMUNITIES.

CERTAINLY, NOT ALL THE PROBLEMS HAVE BEEN SOLVED THROUGH THESE COOPERATIVE EFFORTS, BUT THE LINES OF COMMUNICATION ARE OPEN SO THAT OUR ATTENTION AND OUR RESOURCES CAN BE ALLOCATED TO AREAS OF GREATEST CONCERN.

OVER THE YEARS, THROUGH THIS TYPE OF COOPERATIVE EFFORT AND COLLABORATION AMONG VARIOUS ENTITIES IN BOTH THE PUBLIC AND PRIVATE SECTORS, WE'VE SUCCEEDED IN ESTABLISHING IMPORTANT ADVANCES FOR IMPROVING MATERNAL AND INFANT HEALTH SUCH AS GUIDELINES FOR MATERNAL NUTRITION AND DEVELOPMENT OF NEONATAL INTENSIVE CARE UNITS AND PERINATAL REGIONALIZATION.

WE'RE PLEASED TO WORK WITH THIS COMMISSION. YOUR INSIGHTS AND ADVICE ARE WELCOME AND WILL UNDOUBTEDLY PROVE VALUABLE AS WE ALL WORK TOGETHER TOWARD THE COMMON GOAL OF THE BEST START IN LIFE FOR ALL INFANTS.